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MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

S. 1265

TO AMEND THE PUBLIC HEALTH SERVICE ACT AND THE FAIR LABOR STANDARDS ACT OF 1938 TO PROVIDE MINIMUM HEALTH BENEFITS FOR ALL WORKERS IN THE UNITED STATES

JUNE 24, 1987

PART 1

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MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

WEDNESDAY, JUNE 24, 1987

U.S. Senate,
Committee on Labor and Human Resources,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in room SD–430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Hatch, Quayle, Thurmond, Harkin, Stafford, Weicker, Dodd, and Mikulski.

OPENING STATEMENT OF SENATOR KENNEDY

The Chairman. We will come to order.

We have some additional materials that have been made available to us about the impact of our particular legislation, which I will further explain in the course of my opening statement. I will file my complete statement in the record, but I think these charts displayed in our hearing room are useful in examining exactly what our legislation does and what it does not do.

I am pleased to open this hearing on S. 1265, the Minimum Health Benefits for All Workers Act of 1987. This legislation will remedy one of the most glaring gaps in American society—the gap in a health care system that leaves millions of workers without health insurance or without coverage that is adequate by any reasonable standard.

Each of these uninsured individuals is a tragedy waiting to happen—and the problem is getting worse. Since 1980, the number of uninsured Americans has grown by more than a million a year.

The Health Benefits for All Workers Act is an effective and practical response to this situation. It is based on the proposition that workers and their families should not be forced to play Russian roulette with their health because their employers don't provide protection and they can't afford private policies. This bill assures that all workers and their dependents will be provided at least a minimum package of health insurance coverage by their employers.

This legislation establishes no massive bureaucracy, and it does not increase the Federal deficit. Instead, it builds on the private, employment-based health insurance system that serves most Americans well today. By extending this system to those who have been left out, it assures that no workers will be denied the health insurance they need to protect themselves and their families.

Our first hearing on Minimum Health Benefits examined the legislation from the perspective of ordinary citizens, health experts and health care-givers. In this hearing, we will hear from representatives of business, labor and the insurance industry.

As we shall hear this morning, there is support for this legislation among some progressive businesses, and I expect that support to grow. The public interest and private interest often coincide. These corporations understand that the current system victimizes millions of uninsured Americans. They also recognize that it has a bottom line effect as well, because the current system forces the responsible majority of firms to pay for obligations that should be carried out by the irresponsible minority.

The shifting of responsibility and cost under the current system results in unfair competition between businesses, and makes it more difficult for American industry to compete in world markets. The special problems that small businesses face in insuring their workers can be solved by changing the way insurance is sold within the context of a requirement to provide it.

Much opposition remains. Much of it is ideological. And much of it has overtones of the opposition to Social Security, Medicare and other reforms of another generation. There is no divine right or constitutional right to run a sweatshop or use child labor or deny health insurance. This hearing will help us separate objections that have merit from those that are motivated by ideology and self-interest. We welcome suggestions to improve this legislation, and we are ready to work with anyone to do so.

The economic and business effects are important, but as the following charts show, the human benefits are important too.

CHART NO. 1—TWO THIRDS OF THE UNINSURED WILL GAIN HEALTH INSURANCE FROM THE LEGISLATION

This chart shows that of the total 37.1 million uninsured Americans, two thirds would gain insurance as a result of enactment of the Minimum Health Benefits Act. That's 24 million working men and women and their families who would be helped by this measure.

CHART NO. 2—ALL FULL-TIME WORKERS AND THEIR FAMILIES ARE GUARANTEED INSURANCE

This next chart shows the reason why such a large proportion of the uninsured gain coverage under Minimum Health Benefits. The vast majority of the uninsured are full-time workers. They work hard—most of them 40 hours or more a week, fifty weeks a year—but they still cannot obtain health insurance for themselves and their families, because their employers do not offer it.

CHART NO. 3—CURRENTLY INSURED WORKERS AND DEPENDENTS GAIN CATASTROPHIC PROTECTION

Large numbers of workers who currently have insurance are still potentially at risk of catastrophic costs, because their insurance has no provision to limit out-of-pocket costs for covered services. According to the Department of Health and Human Services, 53 million people are covered by employment-based policies like this.

All of these people will be assured of catastrophic protection by the passage of Minimum Health Benefits.

CHART NO. 4—1,900,000 FAMILIES ANNUALLY BENEFIT FROM CATASTROPHIC PROTECTION

Two million, four hundred thousand families currently experience catastrophic costs in excess of $3,000 annually as the result of serious illness. Almost 80 percent are working families; under this legislation, the annual amount they would have to pay for covered services would never exceed $3,000.

CHART NO. 5—ADDITIONAL GROUPS THAT BENEFIT

This chart shows more specific data on the types of people who would benefit:

More than seven million uninsured children will gain access to essential health care. Almost three hundred thousand disabled children will be insured. Four hundred thousand pregnant women each year will be assured cost-effective, essential pre-natal and well-baby care.

More than 11,000 uninsured families have high-risk infants that accumulate an average of $35,000 per year in hospital charges. All will be protected under this legislation.

Every family that is currently insured but has a medically uninsurable family member will benefit from this legislation. These families today must live with the fear that any job opportunity which involves changing employers could mean loss of health insurance and financial devastation. There are 7 million people in this situation today. By prohibiting preexisting condition exclusions, the legislation will allow these people to take the employment that offers the most opportunity, not the one that offers the most health insurance.

Finally, the legislation assures that any welfare family that wants to work its way off welfare can do so without fear that gaining a job will mean losing medical care coverage.

CHART NO. 6—COST OF MINIMUM HEALTH BENEFITS

As the next chart shows, the gross cost of the insurance purchased by Minimum Health Benefits is $24.6 billion. The net cost, however, is approximately half this amount, because of the following offsets:

$1.5 billion in administrative savings to small business. Small business currently pays a mark-up that averages 25 percent for sales and administrative costs for firms with less than 25 workers; the mark-up is even higher for the smallest firms. By establishing a system of regional insurers for small businesses, the legislation reduces these costs by 15 percent.

Regional insurers, selected by a competitive process, are required to offer cost-effective managed care systems as one of the options for their clients. This offers the oportunity for additional savings of $2.3 billion.

Ten million people covered by the bill are currently insured by high cost, low value individual policies. The savings from replacing these policies with employment-based group insurance is $3.5 billion.

Charity care currently pays for the needs of many who are uninsured. But charity care is not free care. It is typically paid for either by taxpayers or by higher charges to other paying patients. According to several studies, approximately half of the so-called "free care" would be replaced by the insurance provided under this bill, for an offset of $4.8 billion.

The net cost of Minimum Health Benefits after these offsets is approximately $12.5 billion.

CHART NO. 7—PUTTING THE COST OF MINIMUM HEALTH BENEFITS IN PERSPECTIVE

The $12 billion cost of Minimum Health Benefits is equal to four tenths of one percent of total wages and benefits. It represents less than three percent of national health care costs. The hourly cost to business of providing the minimum package is 40 cents—less than a 15 percent increase in the minimum wage. A preliminary estimate of the three year impact of this legislation on employment using the DRI Quarterly Macro Model is that it will increase the unemployment rate by 0.01 percent—a barely perceptible effect.

CHART NO. 8—BENEFITS OF MINIMUM HEALTH FOR BUSINESS AND THE ECONOMY

The legislation has positive effects for both business and the economy. First, it creates a level playing field. Businesses will no longer be allowed to gain a competitive advantage by failing to insure their workers. Businesses that don't insure will no longer get a free ride, and businesses that do provide insurance will no longer be saddled with the costs of other people's employees.

It will also enhance our ability to compete in world markets, since businesses at the cutting edge of international competition almost universally insure their workers. Yet they are paying too much today, because others pay too little.

Finally, the taxpayers will benefit, because many workers will no longer be foreced to rely on tax dollars for the care they need.

CHART NO. 9—BENEFITS FOR SMALL BUSINESSES

A major concern in any program of this type is its impact on small business. Even among businesses with 25 workers or less, the majority already insure their employees. But they pay a heavy and unfair price for doing so. They face high sales costs and high administrative costs, and they are often prohibited from insuring workers with health problems.

Our legislation creates a system of regional insurers to bring economies of scale to small business and reduce unnecessary overhead. It prohibits insurers from excluding members of small firms from coverage based on health status. It permits new small businesses to offer only the catastrophic portion of the coverage during the first two years, when the firms face the heaviest financial burden. And it gives owners of small businesses the same favorable tax treatment for health insurance coverage that they could obtain if they were the hired managers of large corporations.

CONCLUSION

This legislation offers 24 million workers and their families opportunity for realistic health insurance protection at a price that business can afford to pay. In my view, it is the most important item on the health care agenda of Congress. I look forward to today's hearing as the opportunity to discuss its details with the representatives of those who will be most affected by it.

We are going to hear a good deal about the costs and expenses of this legislation. We have just presented it. And I think it is going to be up to the members of the committee to analyze the basis for reaching these various figures.

We welcome the opportunity to have those figures analyzed in detail, because we will hear many outlandish of claims about this issue. We are very much aware that the quickest way to try and slow down a program is to claim that it will cost the moon and the stars, and I think in fairness to our colleagues and to the Senate, a hard analysis of how we reached these various costs is going to be essential if we expect this legislation to move ahead.

Senator Hatch?

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Mr. Chairman.

I think you hit the nail on the head to a degree, that costs are important, and the question is how can we accomplish what needs to be accomplished without bankrupting small business in this country, and maybe a whole raft of others. Government should not have to rear its ugly head and have costs go off the chart.

We have found through the years, at least over the last few years, it is very difficult to raise taxes around here to pay for things. Therefore, this is an ingenious program to not raise taxes directly, but certainly indirectly, because everybody in America is going to pay for this. Only they are going to pay as much as ten times—maybe as much as 15 times—the cost that if would be if we just faced it directly.

There is nothing easy about this problem, and I commend the Chairman for his innovative ways, yet too costly, of trying to resolve some of these very serious problems in our society.

Every day in our country, employees, employers, State governments and even the Federal Government are faced with the high cost of health care, and there may be as many as 37 million Americans who are uninsured or underinsured in this country. Some Americans are denied access to quality health care because they are unable to pay for it or because they are not covered by health insurance; so it is a problem that we face.

Now, today's hearing, of course, is focusing on Senator Kennedy's bill, S. 1265, a proposal to require every employer as a cost of doing business to provide health care coverage to employees and their families.

Now, I think we can find creative and workable solutions to ensure that every American has access to our health care system. I think we do have gaps to fill; there is no question about that. I want to make sure, however, that our legislative solutions address the real problems we are facing.

Let us just look at some of the facts. Eighty-five percent, or more than 200 million Americans, do have health care coverage. Nine out of ten employees under age 65 have employer group health coverage. Fifteen percent of all Americans are uninsured—and that includes 1 million who are uninsurable because of bad health. The employed insured range widely in age, income, and general health status, and uncompensated health care costs range between $7 and $8 billion annually.

Now, I believe that we in Congress cannot and should not dictate to the private sector how these gaps should be filled. Instead, it seems to me we have to work with the private employers to remove the barriers they experience in providing their employees with adequate health care insurance. And, we should look for solutions that do not cause havoc with our health care marketplace and, of course, our overall economy.

I have heard from employers and employees in Utah; they are concerned about the rising costs with regard to health care. And many experts from Utah have given me their thoughts on possible solutions.

For example, Sidney Paulson, the Senior Vice President of Alta Health Strategies in Salt Lake City, recently cited medical malpractice claims as increasing the cost of health care. He wrote to me and he said,

> Malpractice costs continue to escalate at an unprecedented rate. Providers of care are forced to provide additional testing. How about some attention to this matter, rather than causing merely a shifting of costs to employers?

When Joe Califano testified 8 years ago before this Committee, I asked him, "How much of the total cost of health care do you feel results from just the fear of medical malpractice and the overdiagnosis, the overprescribing, the overreaction to medical malpractice and the fear of those suits?" and he said 35 percent, as I recall. That is a large price to pay. And nothing has been done about it since—we have certainly tried, but there has not been a Congressional solution.

I might add that this doctor I quoted from Utah had other ideas, and said that,

> Solutions like those contained in S. 1265 represent an additional significant cost for employers, and you might add, employees—in fact, everybody in America, regardless of their economic condition or capability.

Employers are not financial deep pockets that can absorb the cost of every proposed program or regulation just because we cannot increase taxes because the government is broke.

Before we go so much further, I think we should remember our last legislative maneuver which mandated a private sector solution to the uncompensated care problem. Two years ago, Congress adopted a provision in COBRA which some said would provide access to lower-cost health insurance for those who no longer had that benefit. Now, that solution, as many of us predicted, is now part of the problem. Many of the witnesses you will hear today will testify about how that law has increased costs and made it more difficult for them to provide health insurance for their own employees.

It seems to me now is not the time for a simplistic solution to a complex problem. S. 1265 creates a single Federal system to dictate what types of health benefits American families have to have, and it forces both employers and employees to pay for it. Now, we cannot know or understand the actual impact this legislation will have on employees, employers, and of course, the availability of jobs and the total cost to our society.

Senator Kennedy, I am concerned that the hearings today may not uncover some of these issues. I have recently learned that some estimates project that the annual cost of your proposal will be $100 billion to both employers and employees, and it will cause a reduction of $25 billion in tax revenues to this country.

Also, this analysis predicts that over one million fewer jobs will be available if S. 1265 is enacted.

So we need more hearings to review these projections. If these assessments prove accurate, I fear enactment of this legislation is not only bad policy, but it is bad medicine for all of America.

In the end, we are going to have to make several hard choices. Ensuring access to quality medical care or health care is a serious national issue that does require our attention. So I commend the Chairman for his innovativeness in bringing it up in this forum. But proposals like S. 1265 that could cost between $25 and $100 billion—and some think maybe even more—to address an $8 billion problem are not the answer.

I urge this Committee to step back and take time to review what this bill will actually accomplish and what it will cost, and I look forward to studying the testimony of all witnesses that will be given today.

I think there have to be better answers than this. I have found that every time the Federal Government becomes part of the solution, costs rapidly go up.

On the other hand, it is ridiculous to sit back and say that we should not do anything, that we should just let the free enterprise system resolve these problems, because it is not resolving the problems for those who are underserved, underinsured, or uninsurable. So we have to come up with some solutions, and to the extent that this creates a good public debate on the issue, I commend the Chairman and those who support this bill for having raised the issue. But I think we have got to look beyond this bill if we really want to solve the problems—not just catastrophic health problems, but economic problems that our Nation as a whole has, that our small business community in particular has, and that business that provides these jobs as a whole has. We cannot ignore those problems.

Let us look at it; let us make sure that we do as good an economic analysis as we can, and let us see if we can resolve it.

But I am grateful to be here, Mr. Chairman. I look forward to reading these records and hearing what everybody has to say.

Thank you, Mr. Chairman.

The **CHAIRMAN**. Thank you very much, Senator Hatch.

We will be glad to visit with the distinguished Ranking Minority Member after the course of the hearings, about the possibility of another day of hearings, if necessary; we will keep an open mind on it.

Senator HATCH. I would be glad to do it.

The CHAIRMAN. We want to address this issue, but we do recognize that it is complex; there are important groups that are reviewing it and studying it in greater detail, and we certainly want to gain their insight.

The record will continue to be open at all times for the submission of additional material on it to our Committee, but I would be glad to visit at the conclusion of these hearings with the Ranking Minority Member to see what an additional hearing might focus——

Senator HATCH. I am grateful to you. I think that would be a good thing, if I could just comment, and I appreciate your graciousness. I do think we will probably need at least one more hearing. But it is a complex subject. This bill will create a tremendous debate, and that is good; I think that is healthy. And I appreciate your holding these hearings.

The CHAIRMAN. The Senator from Indiana.

Senator QUAYLE. Thank you, Mr. Chairman.

First, let me ask unanimous consent that my entire statement be inserted in the record as if given.

The CHAIRMAN. Yes, it will be so included.

OPENING STATEMENT OF SENATOR DAN QUAYLE

Senator QUAYLE. Mr. Chairman, I am pleased that you have scheduled this hearing on your mandated minimum health benefit package. I commend you for holding a hearing on the situation facing those Americans who do not have health insurance. I believe that you have identified an important problem that certainly merits the national attention and congressional consideration have sought to bring to it.

I welcome this hearing as an opportunity to explore why it is that there are so may uninsured Americans today. Once we have that information, I believe that the solutions to what I believe to be a very complex problem will become clear. We are all well aware of the growing numbers of Americans who either have no health insurance or are inadequately insured. But we are also aware of the difficult policy issues that are raised by efforts to remedy this condition.

A careful look needs to be taken at the uninsured population and why various subgroups within this population do not have insurance. We then need to analyze whether it makes sense from a public policy perspective to require society to bear the burden of mandating minimum health benefits for all workers, which will result in fewer jobs and higher prices for consumer goods.

For example, we need to examine the following in more depth: A significant minority of the uninsured in 1985—over 9 percent—lived with a spouse or parent who had coverage from an employer plan; in 1985, among children without health insurance, 20 percent lived with a parent who reported coverage from an employer plan; in 1985, out of the 34.8 million people without coverage, 7.5 million earned in excess of $30,000; 20 percent of the employed uninsured are in their first month of employment and would not benefit from S. 1265.

Before addressing my serious concerns about the employment impact of S. 1265 and all the other mandated mbenefit proposals now pending, I would like to note some of my reservations about the specifics of S. 1265. Given that employees would not have the choice to opt out of coverage, many low wage workers might be unable to afford to meet their other living expenses. Should the Federal Government dictate how such workers should spend their earnings? I am also concerned that there really is no incentive in the bill to contain health care costs. In 1986, Americans spent $1,837 per capita on health; by the year 2000, that figure will be $5,551.

In a period of large Federal budget deficits, it is both economically and politically prohibitive to undertake major new Government spending programs. It is no doubt for this reason that the proponents of expanded entitlement programs are now attempting to advance their social policy goals by mandating benefits—such as the proposals before us today—as a part of the conditions of employment. In the past, it may have been possible for employers to pass on some of the cost of mandated benefits to the consumer in the form of higher prices. In most industries, this is no longer possible.

Two costs proposed to be borne by business are the increase in the minimum wage, which has been introduced by the chairman as S. 837, and the mandated minimum health benefits package also introduced by the Chairman as S. 1265. I believe the objective of raising the minimum wage—to improve the welfare of the lowest wage workers—is a good one. Further, I can hardly quarrel with the intent of S. 1265—to ensure all workers have health care coverage. I am concerned by both proposals not because of the good that they propose to do, but because of the inadvertent harm that these bills and proposals like them may inflict on employment opportunities and our international trading position.

Unfortunately, fringe benefits are not free. Like everything else in our economy, these benefits cost money, and the trade-off for these benefits is that jobs will be lost for those employees who are trying hardest to break into the labor market.

To get a realistic idea of the factors Congress needs to consider in evaluating the mandated benefit proposals that are before us, I think it would be very useful for us to examine the combined effect of bills to amend the Fair Labor Standards Act that the Chairman has proposed. I have attached a chart to my statement, a copy of which is on the poster behind me. This chart shows that, as of January 1, 1989, the combined additional labor costs to employers under S. 837, the Minimum Wage Restoration Act, and S. 1265, the Minimum Health Benefits for All Workers Act, will range from 44 percent for a full-time minimum wage worker to 62 percent for a half-time minimum wage worker.

The increase of minimum labor standards will have an inevitable impact on employment. I feel that a 62-percent increase in the minimum labor cost is too great. I believe many of the members of this committee are familiar with the views of Sar Levitan, a reputable professional economist whose desire to see an increase in the minimum wage is well known. I would like the committee to know that he has authorized me to say that, in his view, any professional economist would believe that a 50-percent increase couldn't help but have an adverse effect on employment in an 18-month period.

In the past 4 years, our economy created over 12 million jobs, most of them in small businesses. Last year alone, over 700,000 new businesses were started in the United States. These are not all Fortune 500 corporations; rather, many were small ones, started by ordinary Americans who risked their life savings to start a business. It is these job-generating businesses that are most sensitive to increases in fixed labor costs. If, to pay for its social objectives, Congress is determined to raise American taxes on business indirectly, then we should institute a system to quantify their cost to society, as well as their benefits to employees.

Surely we should not enact legislation that would impose additional labor costs on business without first seriously and objectively assessing its impact on employment and our international competitiveness. That has not been done here, Mr. Chairman. I think it is important for us to have an objective analysis of the impact that these proposals will have on the economy, on employees and on business, particularly small business.

I do not think there is any doubt, after listening to the Chairman and the Ranking Member, that this is an exceedingly important issue, but also an exceedingly complex issue.

I wonder if I might get staff to put back up the Kennedy chart—I had a difficult time viewing it from this angle—that dealt with the benefits of S. 1265. The first one was to establish competition, and there was something in there about the international competitiveness; I think it was 1 and 3.

Let me just go through some of the points that the Chairman makes as far as support of this bill, very quickly here. I hope the witnesses will focus on this as well.

"Establishes fair competition among businesses." In essence what the Chairman is saying to the opponents of this bill is, that we need to make sure everybody has the same health care benefits in the entire country. Some businesses probably have health care benefits that are more than what is proposed in this legislation; some have less; some do not provide any at all.

But how are we going to establish fair competition by mandating that every employer shall have the same health benefits?

Now, in the guise of establishing competition, how far are we really going to go? Are we going to establish competition by telling every employer what kind of pension benefits they are going to have to provide? Are we going to mandate competition by telling each employer, not what the minimum wage is going to be, but what the wages are going to be?

Now, how far do we think that the Federal Government is going to involve itself in the private sector to establish fair competition? I do not think that this proposal goes in the direction of fair competition; I think that, for those of us who believe in the market forces, there ought to be a least intrusive involvement of the Federal Government. If we are going to start establishing and dictating fair competition through mandated benefits, we are going to have an entirely different private sector down the road than we have today.

The third one says "Increases international competitiveness." At least in my neck of the woods in the Midwest, we construe competitiveness as being able to generate jobs, generate opportunities, the generation of wealth.

Now, obviously, if you are going to place more costs on the employer, and they have to compete in this international competitive arena, this bill is certainly not going to help international competitiveness. If we are going to begin to mandate additional costs and benefits to employers, this flies right in the face of the so-called international competitiveness.

I am not referring solely to this bill; look at the chart that I have up there just to the left of this. This shows the two pieces of legislation that the Chairman is promoting that amend the Fair Labor Standards Act: increasing the minimum wage and mandating minimum health benefits. According to the Chairman's statistics—not mine—and I imagine there are probably on the low side, you can take somehow who is working at minimum wage, and you will have a 44.4-percent increase in the cost of labor.

Now take somebody who is working 1,000 annually, 20 hours per week. That cost to the employer is an additional—62-percent increase of the cost to the employer to do business.

Now, I do not see how we can say that these proposals are going to increase international competitiveness if we are going to add on a 62-percent increase in the cost of doing business. The increase in both of these proposals taken together will have a tremendous disemployment effect.

I believe that many Members of this Committee are certainly familiar with the views of Sar Levitan, a reputable professional economist, whose desire to see an increase in the minimum wage is well-known. I would like the Committee to know that he has authorized me to say that in his view, looking at the chart on the left, any professional economist would believe that a 50-percent increase could not help but have an adverse effect on employment in an 18-month period.

Now, I do not know how disemployment creates additional competition. I do not know how disemployment helps our international competitiveness. And submit that it does not; as a matter of fact, it will hurt competition, and it will certainly hurt our competitiveness.

What we have before us today is a piece of legislation that goes to a very important fundamental problem, but I do think we must look at some of the other aspects of this bill in more detail. Let me just point out a few of them:

A significant minority of the uninsured in 1985, over 9 percent, lived with a spouse or parent who had coverage from an employer plan.

In 1985, among children without health insurance, 20 percent lived with a parent who reported coverage from an employer plan.

In 1985, out of the 34.8 million people without coverage, 7.5 million earned in excess of $30,000. Now, why did those people in excess of $30,000 choose not to have health insurance? We need an answer to that question. If individuals who can afford insurance but decide that they do not wish to purchase it, should the Federal Government in the guise of competition or international competitiveness or reducing the cost to business of currently insuring their workers require that the employer pay for it for these individuals?

Twenty percent of the employed uninsured are in their first month of employment—20 percent—and would not even be affected by S. 1265.

I think these are some of the issues that will have to be explored in more detail; I also think that what we have here is a situation where we are changing gears on how we are going to do what we perceive to be socially and economically responsible.

We are going to have philosophical disagreements on what is socially and economically responsible and what we should be doing to help the economy and also to help the people that we represent.

The old-fashioned way of doing things was to basically create a government program, raise taxes, spend the money, and the Federal Government would do it. Well, there seems to be a fairly strong bipartisan agreement that the government is, for all practical purposes broke; that the deficit is here, and it is going to be here for quite sometime; and therefore, from a political point of view you cannot just create a government program, raise taxes, and go out and do things the old-fashioned way. The old-fashioned way is not the way that is politically acceptable anymore.

The new idea is that since the government can no longer afford to fund these programs, we will just simply allow the private sector to pick up the tab that the Federal Government used to. We will simply mandate employers, the private sector, to do certain things: Minimum health benefits; increase the minimum wage; parental leave, plant closing legislation—all these mandated benefits that are coming down the pike—and you have a whole different viewpoint and a whole different economy from which to operate.

So I think that this is just the beginning of a rather important philosophical discussion. There obviously are disagreements on what we should in fact do from a social and economic point of view, and I look forward to that discussion. I look forward to exploring that with our witnesses, and after the conclusion of these hearings, I look forward to exploring this with the Committee and the entire Senate later on.

Senator THURMOND. Mr. Chairman, I have an opening statement.

The CHAIRMAN. Fine. We will recognize the Senator. We ought to put a 10-minute time on ours, because we are here to hear the witnesses, and we have taken 30 minutes of their time. But we welcome the comments of the Senator from South Carolina.

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Mr. Chairman, recent attention has focused on the serious problem of Americans without health care coverage. Although exact figures are not known, data from the Bureau of the Census estimate that in 1984, 31.8 million Americans did not have health insurance.

Other data recently compiled by private research groups estimate that 35 million Americans do not have coverage. Many of these individuals are unemployed and therefore will not be aided by this legislation.

Yet it is estimated that 69 percent of the uncovered are individuals or dependents of individuals who are employed at least some weeks during the year and that 52 percent are individuals or dependents of individuals employed steadily throughout the year.

The lack of employer-sponsored health care plans, like the absence of other employee benefits, is most severe among smaller firms. According to the Small Business Administration, over 90 percent of firms with 25 employees or more offer health care plans to employees—I repeat, 90 percent of firms with 25 employees or more offer health care plans to employees. Seventy-nine percent of firms with fewer than 25 employees offer coverage; 47 percent with fewer than 10 employees offer coverage.

Not surprisingly, the smallest enterprises are the ones with the least resources to enable them to provide health care plans. They also have the greatest employee turnover rate, and the greatest likelihood of going out of business.

Small businesses are also the companies most responsible for job growth in the past several years—a trend that could be curbed if providing expensive health coverage becomes mandatory.

While the gaps in health coverage are real and need to be addressed, employer-sponsored coverage in the United States is tremendously extensive and should not be overlooked. Approximately 132 million Americans receive employee-sponsored health coverage, which represents 84 percent of the total private health care coverage in this country. Closing the gap in coverage means not only building upon the employer-sponsored system, but also encouraging other programs. Business cannot and should not be expected to provide health care coverage for all Americans.

The requirement to provide comprehensive health care coverage will deter the effects of businesses to contain overall labor costs, to create jobs, and to be competitive.

As renowned Princeton Professor Uwe E. Reinhardt has described it, a mandated health benefit is "a tax on employment and entrepreneurship."

Ironically, at the same time that Americans are acknowledging the need for U.S. businesses to be more competitive, proposals are being considered that would add measurably to the burden of operating an enterprise. Using figures provided by the Chairman, it is conceded that this legislation would add $20 billion to the cost of doing business.

In addition, the small business sector of the U.S. economy has accounted for most of the job growth—60 percent of 17 million new jobs created in American between 1976 and 1984. Imposing enormous new costs will make it difficult for these small enterprises to continue that trend.

Furthermore, given the propensity of Congress in recent years to shift the cost of various benefits to business that were previously borne by government programs, large and small businesses alike have good reason to fear that Congress will show no restraint in imposing the costs of even more expensive benefits upon employers.

After all, the title of this legislation states that the proposed health benefits are minimum. Business has no reason to expect Congress to be satisfied tomorrow with requiring what it today considers minimum benefits.

Mr. Chairman, what alternatives exist to expand health care coverage among employers that do not presently provide such protection to their employees? Three alternatives exist that merit careful consideration.

First, treating unincorporated businesses, such as sole proprietorships, the same as corporations for purposes of the tax deductibility of their health care expenses would encourage coverage by the very small enterprises, where lack of coverage is the greatest. Presently, an unincorporated business may deduct only 25 percent of the expenses of the health care coverage for the business owner. As a result, many such small enterprises do not provide coverage for the owner or the employees. If a full tax deduction were permitted, these proprietors would have an increased incentive to provide coverage.

Second, consideration should be given to some buy-in to the Medicaid system—based on ability to pay—for persons without coverage. This existing system might be modified to serve the needs of people with some means to pay for coverage.

Third, the Federal Government can encourage the establishment and expansion of multiple-employee trusts and other similar arrangements. METs are formed by small firms that band together to obtain health care coverage on a more cost-effective basis than a small firm might achieve alone. Often, METs are sponsored by chambers of commerce or trade or professional associations. Initiatives have been very successful and should be fostered.

All of these alternatives hold forth the likelihood of expanding coverage without the intrusiveness of an inflexible mandate.

Mr. Chairman, over the last 30 years, Congress has engaged in an excessive spending spree. Now, our credit has run out, and we want American business to pick up the tab for new initiatives we wish to pursue.

Mr. Chairman, it would appear that Congress—not satisfied with virtually bankrupting the Federal Government—now turns its attention to American business. We must not put America out of business by imposing further burdensome mandates such as that represented by the legislation under discussion today.

Thank you, Mr. Chairman.

The **Chairman**. Well, you can see we do not have uniformity of opinion on this Committee. [Laughter.]

I am for a mandated system to cover 24 million Americans and 7 million children. And I hope over the course, we are going to hear what our friends who are opposed to that program are for.

Senator Thurmond, I have already introduced that legislation to provide for the smaller businesses, and I would welcome you as a cosponsor. And we can make it a Kennedy-Thurmond or a Thurmond-Kennedy bill, whichever way you want to address that. I think it is an essential part of our program. It was listed in one of our charts up here earlier.

Senator Harkin.

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator **Harkin**. Thank you, Mr. Chairman, for the opportunity to comment today on minimum essential health care. I would say right off that I am generally supportive of S. 1265 as an effort to address the health care needs of America's growing uninsured population—estimated now, I believe, to be somewhere around 37 million men, women and children. I commend the Chairman for his work in negotiating this bill between various interest groups; I know from the mail I receive in my office that there are some pretty strong feelings both ways on this legislation.

As I said, the concept of requiring employees to provide adequate health insurance for employees and their families is one I stand behind. I do have, however, some concerns regarding this specific piece of legislation which I believe can be worked out. I understand that I'm getting into the details of the bill when the focus of this hearing is on its much broader merits, and I won't take up much of your time on this. But I do want my concerns to be on record early on so that perhaps they can be covered in greater detail at furture hearings.

Briefly, I am concerned that the bill, as written, might encourage the elimination of benefits for alcoholism and drug dependency. Drug and alcohol abuse treatment are not specifically required under the sections relating to covered services—title III, sections 311-312. And while such treatments are not prohibited from being offered, I am concerned that any wording which would provide "Federal permission" for employees to exclude this benefit is dangerous to the health of this Nation.

Alcoholism and chemical dependency are currently present in epidemic proportions throughout the United States. The old debate about whether or not they are legitimate disease has been resolved in the medical and legal arena and research is now conclusive with respect to genetic predisposition. Even if you were to assume some sort of "self-inflicted" component to alcoholism and chemical dependency, in that same vein you would have to consider the affects of smoking on lung cancer and heart disease, and the affects of overeating on various other diseases.

In short, I'm afraid that if we at the Federal level allow alcoholism and chemical dependency treatment to be excluded from coverage, we will be setting a terrible precedent for the States—some of which have already passed mandatory benefit clauses to combat the trend by employers to exclude appropriate coverage for these diseases. I believe that mental illness, which now affects one in five families, is also excluded from coverage in S. 1265.

I understand that in negotiating this legislation it was necessary, if the bill is to stand a chance, to keep benefits to a bare minimum. I appreciate the need to compromise. But we are talking here about discrimination—about favoring one disease over a less acceptable one, and I have very serious reservations about us involving ourselves in the business of chooseing what is acceptable.

Again, I support the concepts put forth in S. 1265, and don't want to slow its progress through this committee. I would suggest, however, that our staff might be able to work together to clarify your intent with regard to coverage for alcoholism and drug dependency treatment. I think that we have the data available to us which proves that alcoholism treatment is associated with statistically significant reductions in total health care costs, and that we can work to eliminate any other concerns that you may have with regard to its inclusion in this bill.

In closing, I would just like to once again commend the Chairman for all of his efforts on behalf of the underinsured, and specifically for his work on S. 1265. Thank you, Mr. Chairman, for hearing me out.

The **Chairman.** Thank you, Senator Harkin.

Our first panel is a group of distinguished business leaders who will provide a valuable perspective on the legislation.

Robert Crandall is the President and Chairman of American Airlines, someone who is very familiar with the current competitive pressures on companies offering good health insurance coverage to their employees.

Walter Maher is Director of Employee Benefits for the Chrysler Motors Corporation and is intimately familiar with the difficulties American companies face as they struggle to compete in the world market.

Karl Bays has been deeply involved with the health care industry throughout his career. He is the Chairman of Baxter Travenol Laboratories and sits on many corporate boards.

Would they be kind enough to come forward?

Mr. Crandall, we will start off with your testimony, please.

STATEMENT OF ROBERT L. CRANDALL, PRESIDENT AND CHAIRMAN, AMERICAN AIRLINES, FORT WORTH, TX; WALTER B. MAHER, DIRECTOR OF EMPLOYEE BENEFITS, CHRYSLER MOTORS CORP., HIGHLAND PARK, MI; AND KARL D. BAYS, CHAIRMAN, BAXTER TRAVENOL LABORATORIES, DEERFIELD, IL

Mr. **Crandall.** Thank you, Mr. Chairman.

The **Chairman.** Now, whether you believe it or not after the first 35 minutes, we do have a time problem here. We have a very full agenda, and I know our witnesses have been made aware of this. But we will get all of your testimony in the record and we want you to highlight it, if you would be so good. I think the messages that you have are very important, and I am sure we are going to have some questions, but we would hope that you will cooperate. Mr. Crandall.

Mr. **Crandall.** I thank you, sir. I shall be brief.

I am here in strong support of S. 1265. I think it is good for business. I also think that there will be over time a broad-based corporate support, and I would like to take just a minute or so to explain why.

I think there is a growing consensus that a policy of assuring basic health care benefits for all Americans is simply the right thing to do. I think the time has come to resolve that our people are not going to suffer financial tragedy simply because they have the misfortune of suffering health tragedy. And if for no other reason, I think we should have a national commitment to universal health care coverage because it is clearly in the public interest.

Now, once you accept the premise that a minimum level of health coverage should be universally available, the next question is how should you best structure the program.

As a businessperson, I support this legislative approach because I think it is the most efficient and the least intrusive way to get a major part of the job done.

When you proposed national health insurance several years ago, Mr. Chairman, the business community reacted negatively. It argued then that a public system would be inefficient and wasteful and an unwelcome expansion of government bureaucracy.

Your current proposal, at least in my view, deals appropriately with those objections, and it deserves our support. I think it is vastly superior to a program necessitating massive government involvement, and I think it is far better than the current state of affairs.

Now, as the world is today, companies like ours pay for health care coverage twice—once for our own employees, and then again, by way of taxes and inflated health insurance premiums, for the employees of other companies that do not provide benefits to their own people. Some of those companies, I am sad to say, are our competitors.

Indeed, I fear that we may be now seeing across the United States an unhappy trend by which employers avoid providing health care benefits as a means of obtaining competitive advantage; that is already happening in the airline industry.

Let me be very specific. A few years ago, Continental Airlines used a badly drawn provision of the bankruptcy laws to simply abrogate its labor contract. It then proceeded to slash wages; it also reduced or eliminated most employee benefits, including company-paid health benefits.

From a business perspective, that bankruptcy reorganization was an extraordinary success. From the standpoint of public policy, at least in my opinion, it was anything but.

Among the benefits eliminated by Continental was all medical insurance coverage for its retirees. In my judgment, allowing a company to abrogate its retiree health benefits, particularly when it is done for competitive cost advantage, is obviously contrary to sound public policy.

In less than ten years, American Airlines alone will spend $120 million annually on retiree medical coverage, $10 million a month. Ours is a very competitive business. We simply have to charge the same ticket prices as any other airline. And we cannot live with a cost handicap of that magnitude. So unless that situation changes, we are going to have to take action to scale down or eliminate our own retiree health benefits.

Now, we do not want to do that, and for that reason, I urge the Committee to consider expanding this bill to include mandated retiree benefits, thereby bringing companies like Continental and others back into the 20th century.

I am sure some will say that by urging mandatory health benefits, I am turning my back on the principles of the Airline Deregulation Act of 1978, a piece of legislation with which the Chairman of this Committee is most familiar. That is simply not the case.

Lower airline fares that result from enhanced marketplace competition, from improved productivity, from the elimination of unnecessary frills and from increased efficiency are without question desirable from the standpoint of national policy. But I do not believe that deregulation was ever intended to encourage companies that fail in the competitive marketplace to rectify that failure by slashing such essential benefits as health care for active and retired workers.

There is one additional reason for embracing this legislation, and that is that it gives employers a stake in the health of their employees. Progressive companies across the country already work with employees to reduce illness and accidents and to encourage fitness and good health, not only because it is the right thing to do, but also because it is cost-effective. That incentive is not present for those employers who have no direct financial stake in the cost of health care.

To summarize my views, the legislation we are discussing today will, in my opinion, accomplish four important objectives.

First, it will serve to keep responsibility for health care in the private sector.

Second, it will provide a more equitable distribution of health care costs.

Third, it will eliminate a growing practice of reducing health benefits for competitive advantage.

And fourth, it will provide incentives for employers to expand workplace health programs as a means of containing health care costs.

That concludes my remarks, Mr. Chairman. I will be happy to participate in responding to your questions.

The CHAIRMAN. Fine. Thank you.

[The prepared statement of Mr. Crandall follows:]

Statement of Robert L. Crandall
Chairman and President
American Airlines, Inc.

Before the United States Senate
Committee on Labor and Human Resources

June 24, 1987

My name is Robert L. Crandall. I am Chairman and President of American Airlines. I am here in strong support of S. 1265. In fact, if I have any criticism it is that the bill does not go far enough, as I will discuss in a moment.

While business support for this legislation may be slow in coming, I am convinced that it will develop. Let me explain why.

First and foremost, there is a growing consensus that a policy of assuring basic health care benefits for all Americans is simply the right thing to do. Our current system has left millions of Americans without any health coverage whatsoever, and millions more inadequately covered. Unforeseen health care expenditures can have a devastating impact on the economic well-being of families. Insurance or prepaid care can prevent a health tragedy from turning into a financial tragedy as well.

None of us in this room would dream of being without health insurance. Why should we, who are better able than most to pay out of pocket for medical care, be insured while those less able to afford it go without? It is time for us, as a nation, to resolve that our people should not suffer or die for lack of basic medical care. If for no other reason, we should have a national commitment to universal health care coverage because it is the right thing to do.

Once you accept the premise that a minimum level of health care should be universally available, the only question is how to assure it happens. As a business person, I support the legislative approach in S. 1265 because it is the most efficient and least intrusive way to get a major part of the job done. It eliminates cross-subsidies and may even reduce government expenditures.

When you proposed national health insurance several years ago, Mr. Chairman, the business community reacted negatively. It argued that a public system would be inefficient, wasteful, and an unwelcome expansion of government bureaucracy. Your current proposal, in my view, deals appropriately with those objections and deserves our support. It is vastly superior to a program necessitating massive government involvement and it is far better than the current state of affairs.

Today, companies like ours pay for health care twice -- once for our own employees and then again, via taxes and inflated health insurance premiums, for the employees of those businesses who don't provide benefits for their own people.

While tens of millions of Americans do not have health care insurance, only a very few actually go without health care. Some of the uninsured pay their own way, but the majority rely either on public health programs or charitable services.

Let me make it clear that American Airlines does not object to paying its fair share of the health costs of low income individuals and senior citizens. But we do object to paying for the health care costs of individuals employed by or retired from other businesses, some of whom may even be our competitors. And that is precisely what is happening today. It is absolutely inequitable to allow some businesses to shift these costs to others.

Indeed, I fear that we may be seeing the beginning of an unhappy trend by which employers will avoid providing health care benefits as a means of obtaining cost advantages over their competitors. It has already happened in the airline industry.

This hearing is a unique opportunity for me because the Chairman of the Committee is not only an expert on health and benefit issues, he is also an expert on the economics of the air transportation business. Indeed, few people in public or private life have had such a profound impact on my industry as did you, Mr. Chairman, in leading the Congress to enact the Airline Deregulation Act of 1978.

I raise this point because much of the recent criticism of the airline industry is misdirected. Those who blame airline deregulation for today's airline service problems are simply misinformed. And I say this as one who did not support the concept of deregulation when it was first proposed in the Congress. Air travel volume has doubled since the advent of deregulation; many people who could not afford to fly then now do so regularly.

Today's airline service problems have resulted not from deregulation per se, but from a variety of other problems including the policies of a few airlines that directly involve this Committee's jurisdiction. For reasons unrelated to deregulation, some companies have obtained a competitive edge by going to extraordinary lengths to cut employee wages and benefits -- including health benefits. If you are opposed to those practices and don't want them to spread to other industries, you should pass this legislation.

Let me be more specific. A few years ago, Continental Airlines used a badly drawn provision of the bankruptcy laws to abrogate its labor contracts. It then not only slashed wages, but also reduced or eliminated most employee benefits, including company-paid health benefits. From a business perspective, Continental's bankruptcy reorganization was an extraordinary success. It has since emerged from bankruptcy and its parent -- Texas Air -- is now the nation's largest airline company. From the standpoint of public policy, it is a different question. As a result of the reorganization, Continental's wage and benefit costs are now about half those of many other airlines.

You don't have to be a business genius to figure out that when a company has labor costs that are twice that of a larger competitor, something has to give. Among other things, medical benefits for Continental employees were cut to levels substantially below industry standards. They even fall below the minimal benefits mandated by S. 1265. For example, employees at Continental must pay $360 to $600 per year for family health insurance. Our employees pay nothing after their first year on the job. Continental's deductibles are between $300 and $900 per person. Ours are $100.

We asked our insurance department to estimate the savings for American Airlines in health insurance costs if we adopted Continental's policy. It amounts to $60 million per year.

Compounding this problem is the fact that Continental also eliminated all medical benefits for its retirees. In my opinion, allowing a company to abrogate its retiree health benefits to gain a competitive cost advantage is contrary to sound public policy. For an employee who was counting on medical benefits following retirement, this action was nothing short of a personal tragedy. For those of us who compete against Continental, it creates nearly irresistible pressure to cut our own retiree medical costs. In less than ten years, American's costs for retiree medical coverage will be over $120 million annually. Ours is a highly competitive business, and we simply cannot live with a cost handicap of that magnitude. So -- unless the situation at Continental changes -- we will soon have to take whatever action is necessary to scale down our retiree health benefits.

For this reason, I urge the Committee to consider expanding the bill to include mandated retiree benefits, thereby bringing companies like Continental back into the 20th century.

When we look at the full wage and benefit packages of the two airlines -- those applicable to active employees as well as retirees -- the numbers become even more ominous. Continental's wage and benefit cuts have given it an advantage over us of more than $50 million every month -- about $600 million annually. Now, low airline fares that result from enhanced efficiency, improved productivity, and elimination of unnecessary frills are without question desirable from the standpoint of national policy. But low airlines fares that are the result of the victimization of employees through massive wage and benefit cuts, are to me

-- and I believe to the nation -- an entirely different matter.

As the Chairman well knows, in the airline business most costs do not vary much from one company to another. We all pay about the same for fuel, equipment, food, airport space, and so on. The only significant difference between airline operating costs is in the wage and benefit category. If airlines are forced to make drastic cuts in these costs to match those of Continental, we and our employees and our customers have some painful times ahead.

In my view, permitting companies to skimp on employee and retiree benefits like basic pensions and adequate medical insurance in order to gain competitive advantages is simply not sound public policy. If this is the beginning of a trend, our nation is in deep trouble -- and now is the time to put a stop to it.

If I may have the liberty, Mr Chairman, I would like to direct one remark to my business colleagues who may be here today. We have a unique opportunity with this legislation. There is, in my view, an increasing recognition by both business and labor that as our nation struggles with an enormous trade imbalance, we are all in this fight together. As we search for ways to enhance our productivity and improve our competitiveness, many of us have come to admire and even envy the cooperative relationship of Japanese workers and businesses. One of the keys to Japanese productivity is the commitment of its businesses to the needs of their employees.

In studying this proposed legislation, we have spent time with the health policy leadership of the AFL-CIO. We have been most impressed by the total understanding -- indeed firmness -- of organized labor that this package must not be loaded down in a way that will harm U.S. productivity.

If there was ever an opportunity to turn the corner on the problem of getting management and labor to work together, this is it. To the vast majority of U.S. businesses who already meet or come close to meeting the requirements of this proposed legislation, I say -- let's seize this opportunity to join in common cause with labor to set minimum health care standards and, in so doing, make a commitment to the idea that no working American should become impoverished by the need to pay for health care.

Not only would embracing this legislation promote a spirit of cooperation and understanding between business and labor, it will save us all money in the long run. When an employer has a stake in the health of its employees, it is much more inclined to provide a work atmosphere that encourages fitness and good health. Progressive companies work with their employees to reduce illness and accidents -- not only because it is the right thing to do, but also because it is cost-effective. That incentive is substantially less if employers have no direct financial stake in the cost of health care. If every company pays its fair share of health costs, I believe that workplace health programs will expand and that the nation's total health care costs should therefore fall.

In summary, this proposed legislation will accomplish four important objectives: First, it will serve to keep responsibility for health care in the private sector, where it can be administered on the most cost effective basis. Second, it will provide a more equitable distribution of health care costs. Third, it will eliminate a growing practice of reducing health benefits for competitive advantage. Fourth, it will ultimately lower total health care costs as more employers attach importance to maintaining the good health of their employees.

The **Chairman**. Mr. Maher.

Mr. **Maher**. Thank you, Mr. Chairman.

My name is Walter Maher. I am Director of Employee Benefits for Chrysler Motors, and I appreciate the opportunity to be here today in support of the principles of your bill.

We have developed in America essentially a tripartite method for financing health care for our citizens. The Federal government underwrites the Medicare Program for the elderly; the Federal and State governments fund the Medicaid Program for the poor, and finally, businesses in general have responded to the needs of their employees by fostering the development of a private health insurance system for most of the employed population.

Indeed, data suggests that the workplace is the source of almost 85 percent of all private health insurance coverage.

While none of these systems is perfect, they do provide a framework for a national policy which could ensure access to adequate health care coverage for all Americans.

Regrettably, despite this framework which has evolved over the past 40 years, the admirable and necessary societal goal we seek is eluding us.

Budget deficits, coupled with an inability to control program costs, have caused both Medicare and Medicaid benefit cutbacks and cost shifts to private payers.

The absence of more uniform Medicaid eligibility rules have rendered some State programs inaccessible to many impoverished families, again shifting costs to the private sector. And approximately 70 percent of the 37 million Americans currently uninsured are employed or dependents of workers usually in lower-paying jobs not offering health benefits.

None of these problem areas are close to being resolved, and indeed, the situation appears to be worsening. For this reason alone, we applaud you for bringing the issue of required employment-based health insurance to the table for the debate it deserves.

Indeed, it appears that this bill would provide the glue necessary to piece together throughout the country a uniform method of providing health insurance coverage, which has for some time been widely adopted by the majority of American businesses, both large and small.

There is another equally compelling reason for our support of what you seek to accomplish here. It is competition. Chrysler offers comprehensive health protection for our employees and retirees. We, with the cooperation of the UAW, have introduced several innovative programs to control the cost of this coverage. Yet despite these efforts, our health care bill this year will approach a half billion dollars. This represents well over $300 per car. And we take little comfort in the fact that General Motors and Ford offer comparable protection for their employees and retirees and incur comparable costs. We are not playing in an American-company-only ballgame. The "Big Three" is now the "Big Thirty and Counting." In fact, the count has reached 37. Taiwan, Brazil, Malaysia—all the newly-industrialized countries in the world, with wage rates as low as $1.19 an hour—are rushing in to claim a piece of the world's richest market, almost one-third of which has already been claimed by Japan and Germany and the other developed countries. None of them have to cope with the cost of a health system as we do in America.

One factor aggravating health care costs is that when so-called charity care is provided to the uninsured in America, the cost is passed on to others in the form of higher health care charges to paying patients, and higher premiums to firms that provide insurance. It also puts pressure on public health systems, which serves to increase taxes required to fund such systems.

Given the competition we face, it is unfair that a minority of employers, usually those not facing foreign competition, can effectively let someone else pick up the tab for their employees' health expenditures.

In addition, with the growth of female employment in the United States, and particularly married females, there is a temptation for employers not to provide insurance if they know that their employee's spouse is well-covered.

Very simply, we believe that companies like Chrysler, which have already assumed a significant financial responsibility to provide employee health coverage, thereby alleviating pressures on public systems, should not be allowed to be a dumping ground for other companies' health bills.

Now, we are mindful that some in the business community oppose what this bill seeks to accomplish even though their firms already offer health insurance plans equal or better than the minimum plan specified in this bill. They are not without a basis for their concerns. Recent government forays into the health benefits arena have provoked many employers. TEFRA, DEFRA, COBRA all related in some manner either to the government's efforts to tackle the problem of providing access to health coverage on a piecemeal basis, as opposed to the method proposed under this legislation, or to government's attempt to relieve its budget crisis by saddling the already overburdened business health care budgets with the responsibility for paying for what previously was a Medicare responsibility.

The bill you have introduced, Mr. Chairman, affirmatively seeks to allay some of these fears. For example, the benefit plan design avoids rigid prescriptions, and permits a significant amount of employer flexibility. Another positive feature which small businesses particularly should find attractive is its effective elimination of the plethora of State-mandated benefits.

There are broader issues, however, which must be addressed. If government, through this bill, expects the business community to fulfill its role in the tripartite system by providing coverage for the employed in America, then our collective governments must fulfill their responsibilities as well.

The Medicare Program must be adequately funded, and the slow and painful cost-shifting to the business community must cease. We must also have more uniform Medicaid eligibility requirements. We cannot honestly say that we have a health care system for the poor when a family of three in Texas with an annual income of $2,209 fails to qualify for AFDC and thus cannot get a Medicaid card. That is less than 25 percent of the poverty level.

In conclusion, let me reiterate that Chrysler is pleased to appear here today and express our support for what you seek to accomplish through this bill. We are convinced it represents both good social policy and is equitable for the business community.

Thank you.

The **Chairman**. Thank you very much.

[The prepared statement of Mr. Maher follows:]

STATEMENT
OF
WALTER B. MAHER
DIRECTOR - EMPLOYEE BENEFITS
CHRYSLER MOTORS CORPORATION

before the

U.S. SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES

June 24, 1987

Mr. Chairman and Members of the Committee, my name is Walter B. Maher. I am Director of Employee Benefits for Chrysler Motors Corporation, and I appreciate this opportunity to express our support for the principles underlying the Minimum Health Benefits For All Workers Act of 1987.

Just about everyone subscribes to the view that all Americans should have access to affordable, quality health care. And it's a good thing that this consensus exists because no thoughtful person, having the means, would willingly be without health insurance. The potential cost consequences of a serious medical problem are simply too financially catastrophic to do otherwise. Further, knowing that one has insurance protection substantially eliminates what otherwise could be a financial barrier to obtaining needed medical attention at the onset of a health problem.

Unfortunately, the cost of health care in the United States has escalated beyond the levels existing anywhere in the world. As a result, insurance coverage for the man on the street is extremely expensive and at times unavailable.

Fortunately, however, we have developed in America essentially a tripartite method for financing health care for our citizens. The Federal government, assisted by beneficiary payroll taxes and premium payments, underwrites the Medicare Program for the elderly. The Federal and state governments fund the Medicaid Program for the poor. And finally, businesses in general have responded to the needs of their employees by fostering the development of a private health insurance system for most of the employed population. Indeed, data suggests that the workplace is the source of almost 85% of all private health insurance coverage.

While none of these systems is perfect, they do provide a framework for a national policy which could ensure access to adequate health care coverage for all Americans.

Regrettably, despite this framework which has evolved over the past 40 years, the admirable and necessary societal goal we seek is still eluding us.

Budget deficits, coupled with an inability to control program costs, have caused both Medicare and Medicaid benefit cutbacks and cost shifts to private payers.

The absence of more uniform Medicaid eligibility rules has rendered some state programs inaccessible to many impoverished families thereby shifting the cost of any health care rendered to them onto the health care delivery system and, ultimately, to those financing it, including the private sector.

And, while over 130 million Americans under age 65 receive their health coverage through their employers, approximately 70% of the approximately 37 million Americans who are currently uninsured are also employed or dependents of workers, usually in lower-paying jobs not offering health benefits.

None of these problem areas are close to being resolved. Indeed, the situation appears to be worsening. Notwithstanding the wide availability of health coverage and the fact that the nation has experienced a period of relative prosperity for the past five years, never since the introduction of the Medicare and Medicaid programs over 20 years ago have there been as many Americans not included under established public or private health plans as there are today.

For this reason alone, we applaud you for bringing the issue of required employment-based health insurance to the table for the debate it deserves. The need is clearly there; the benefit plan design you have chosen is consistent with benefit plan designs frequently found in private sector programs; indeed, it appears the Bill simply provides the glue necessary to piece together throughout the country a uniform method of providing health insurance coverage which has for some time been widely adopted by the majority of American businesses, both large and small.

There is another equally compelling reason for our support of what you seek to accomplish here. It is competition. Chrysler offers comprehensive health protection for our employees and retirees. We, with the cooperation of the UAW, have introduced several innovative programs to control the cost of this coverage. We actively promote enrollment in alternative health plans such as Health Maintenance Organizations and Preferred Provider Organizations. Yet, despite these efforts, our health care bill this year will approach a half billion dollars. This represents well over $300 per car. We take little comfort in the fact that General Motors and Ford Motor Company offer comparable protection for their employees and retirees and incur comparable costs. We are not playing in an American-company-only ballgame. The Big Three is now the Big Thirty, and counting. In fact, the count has reached 37. Taiwan, Korea, Brazil, Malaysia — all the newly-industrialized countries in the world, with wage rates as low as $1.19 an hour, are rushing in to claim a piece of the world's richest market — almost a third of which has already been claimed by Japan and Germany and the other developed nations. None of them have to cope with the cost of a health system as we do in America.

"Competitiveness" is a term increasingly being used in Washington. And with good reason. Not too long ago, we looked at how our employee health care costs compared with those of our Japanese partner, Mitsubishi. We found that our costs were over three times greater. We realize, of course, that the Japanese social system is different from ours and that, to some extent, those differences impact health care costs. However, the fact is it's extremely tough for American companies to be competitive with Japanese companies when you're carrying a differential in health care costs like this.

One factor aggravating health care costs is that when so-called "charity" care is provided to the uninsured in America, the cost is passed on to others in the form of higher health care charges to paying patients and higher premiums to firms that provide insurance. It also puts pressure on public health systems, which serves to increase taxes required to fund such systems. At Chrysler, we already pay handsomely to provide the health care coverage we do. Given the competition we face, it is unfair that a minority of employers, usually those not facing foreign competition, can effectively let someone else pick up the tab for their employees' health expenditures. Further, the employees

impacted are typically low paid, and can thus ill afford to buy insurance on the inflated private market for individual policies. As a result, they often defer seeking care until they are more severely ill, thus increasing the cost of the ultimate "charity care" rendered.

In addition, with the growth of female employment in the U.S., and particularly married females, there is a temptation for employers not to provide insurance if they know their employee's spouse is well covered. Given the fact that our company is 85% male, 66% married, and all well covered, I think you can understand our concern in this regard. Very simply, we believe that companies like Chrysler, which have already assumed a significant financial responsibility to provide employee health coverage, thereby alleviating pressures on public systems, should not be allowed to be a dumping ground for other companies' health bills.

We are mindful that some in the business community oppose what this Bill seeks to accomplish, even though their firms already offer health insurance plans equal or better than the minimum plan specified in this Bill. Some take this position simply because they oppose government mandates. Others take their stance because they do not comprehend the cost-shifting which is occurring to their detriment under the current system.

Those who oppose this Bill on philosophical grounds are not without a basis for their concerns. Recent governmental forays into the employee benefits arena, and specifically with respect to health care, have provoked many employers. TEFRA, DEFRA and COBRA all related in some manner either to the government's effort to tackle the problem of providing access to health coverage on a piece-meal basis, or to

government's attempt to relieve its budget crisis by saddling the already over-burdened business health-care budgets with the responsibility for paying for what previously was a Medicare responsibility. Current thrusts, such as the High Risk Notification Bill, also lend credence to the arguments of those prone to knee-jerk negativism regarding government mandates.

The Bill you have introduced, Mr. Chairman, affirmatively seeks to allay some of the fears of the business community in this regard. The benefit-plan design avoids rigid prescriptions and permits a significant amount of employer flexibility. Another positive feature, which small businesses particularly should find attractive, is its effective elimination of the plethora of state-mandated benefits. In view of the proposed national minimum standards, the Bill should go further and eliminate the recently-enacted non-discrimination rules which would appear to be unnecessary. To counter the "foot-in-the-door" concern, the Bill provides that no benefits may be added to the plan design unless the cost consequences have been analyzed and the Federal and state governments have likewise assumed responsibility for such coverage under the Medicaid program. Finally, we are pleased that employers would be able to satisfy their obligations under the Bill by offering only HMO or PPO coverage.

There are broader issues, however, which must be addressed if we truly expect to accomplish the objective of providing all with access to coverage. If government, through this Bill, expects the business community to fulfill its role in the tripartite system by providing coverage for the employed in America, then our collective governments must fulfill their responsibilities as well. The Medicare program must be adequately funded and the slow and painful cost-shifting to the business community must cease. We must also have more uniform Medicaid eligibility requirements. We cannot honestly say we have a health care system for the poor when a family of three in Texas, with an annual income of $2,209, fails to qualify for AFDC and thus cannot get a Medicaid card. That's less than 25% of the poverty level!

Finally, other forms of indiscriminate cost-shifting to business, such as we see in COBRA, should be eliminated or, at the very least, revisited, with the thought of exempting those employers who had previously provided access to coverage for separated workers or who had funded such coverage.

In conclusion let me reiterate that Chrysler is pleased to appear here today and express our support for what you seek to accomplish through this Bill. We are convinced it represents both good social policy and is equitable for the business community. As you stated on May 21, Mr. Chairman, when you introduced this Bill, it may not be perfect legislation; adjustments may be required. However, whatever adjustments one may seek, we share your belief that there are no convincing arguments against the need to assure basic access to essential health care to all American workers and their families.

(WBM/6)

The CHAIRMAN. Mr. Bays.

Mr. BAYS. Thank you, Mr. Chairman.

May I say that I am Director and Chairman of the Finance Committee of one of Mr. Crandall's competitors, Delta Airlines, and I share his feelings about Continental and some of the things that they got away with.

But I am here as Chairman of Baxter Travenol Laboratories, and I very much appreciate the opportunity to testify before this Committee.

Baxter employs 58,000 people around the world. About 40,000 of them are in the United States. We offer 120,000 products for health care, and our annual sales are more than $5.5 billion.

I have been privileged for 30 years now to serve the Nation's health care system, and that is a system that is rightly called the envy of the world. I have had the opportunity to look at health care from the vantage point of a manufacturer, an employer, a hospital trustee, a member of the Prospective Payment Commission, and an adviser to the Department of Health and Human Services, as well as three Presidents. And what I have learned is that health care in this Nation is not just an essential social service. It is our second-largest employer. It is a source of competitive strength in international commerce.

There are two essential characteristics of the excellence of our system. One is the pluralistic way in which we make use of both public and private resources to serve the health needs of our people. And the other element is the attitude of progress that has always inspired American medicine.

The excellent health care enjoyed by Americans today is a product of the provident actions that were taken by those who came before us, and I think there is a need for similar action today, and that is why I support the bill that the Chairman is supporting.

Because as great as our health care system may be, there can be no debate about the glaring shortcomings that still exist. There are huge unmet health needs felt by people in cities and rural locations across the country. It is well-known and been mentioned here this morning several times that the number of people uninsured for health care in this country has grown to a level of 35 million. Indeed, I heard the number 37 million earlier.

Many of those people are truly middle Americans, and most of them, or at least half of them, have jobs.

The effects on the people themselves are already clear. They have greater needs for health care and less access to it.

What is not as widely noticed or appreciated is that particularly in recent years, the system has been asked to pick up the slack. In constant dollars, the amount of uncompensated care provided by hospitals grew 50 percent from 1981 to 1984. It reached a level of $6.9 billion, or an average of more than $1 million at every hospital in the country.

Now, it may be tempting to think that this trend will somehow work itself out and go away. But I can assure you that it will not. No other group of people or organizations in this country is expected to provide a service, let alone such a vital service, without getting paid for it. And I do not think we should ask hospitals to do that, either.

It may also be tempting for each party that is concerned with this issue to look to others for resources and solutions. But that is not an option, either.

Hospitals and other providers of health care have been working diligently during the decade of the eighties to make this Nation's health dollars work harder and more productively. That effort obviously must continue.

Companies serving hospitals—and I put mine at the top of that list—have a major role as well. But I feel that the government has an obligation in this matter, also. It must not continue to constrict eligibility and coverage levels for the poor, the elderly and the disabled.

And I also feel that private payers, including business—my own company included—must uphold our obligations as well. I say that with the view that we must continue this pluralistic system and the view that this is best for the Nation.

So I think there is plenty of responsibility to share, and there can be no doubt that the American people look to all of us involved to do our share.

Therefore, Mr. Chairman, there are two major reasons why we favor the Minimum Health Benefits for All Workers Act. The first is that it fits with our pluralistic approach to health care. To state that same point in a different way, it would keep some necessary health care dollars from having to travel through Washington.

Money spent on health care works best and works hardest when it follows the shortest possible route from the payer to the point of patient care, and we should avoid side trips through government agencies whenever possible.

My second reason for favoring this Act is that it is progressive; it recognizes a serious need. It admits that we must act now on that need. It provides a way to improve our great system of health care not just for today, but also for those who will come after us in the years ahead.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Bays follows:]

STATEMENT OF

KARL D. BAYS

CHAIRMAN

BAXTER TRAVENOL LABORATORIES

BEFORE THE

SENATE COMMITTEE ON

LABOR AND HUMAN RESOURCES

ON

ACCESS TO HEALTH CARE

JUNE 24, 1987

Mr. Chairman, I'm Karl D. Bays, board chairman of Baxter Travenol Laboratories, and I very much appreciate the opportunity to testify on the important matter of access to health care that this committee is now studying.

Baxter employs 58,000 people around the world. About 40,000 of them are in the United States. We offer 120,000 products for health care, including everything from sophisticated diagnostic systems to single-use surgeon's gloves.

I've been privileged for 30 years now to serve this nation's health-care system--a system that's rightly been called the envy of the world. U.S. health care today encompasses the resources and the efforts of 550,000 medical doctors, 1.5 million nurses, 6,900 hospitals, 335,000 clinics, and a total of 8.5 million employees in corporations and other organizations across the country.

I've had the opportunity to look at health care from the vantage point of a manufacturer and employer, a hospital trustee, a member of the Prospective Payment Assessment Commission, and an adviser to the Department of Health and Human Services as well as three presidents. I've learned that health care in this nation is not just an essential social service. It's our second largest employer. It's a source of competitive strength in international commerce.

There are two essential characteristics of the excellence of our system. One is the pluralistic way in which we make use of both public and private resources to serve the health needs of our people. The other element is the attitude of progress that has always inspired American medicine.

Time and again, in just our recent history, we've confirmed both of those characteristics.

The National Institutes of Health were founded in 1930 to foster research. The Hill-Burton Act was passed in 1946 to assist in building hospitals where they didn't then exist and to improve those that did. In 1940, only 12 million Americans had hospitalization insurance. By 1960, largely through employee benefits programs, 123 million were covered against hospitalization.

Undoubtedly, our largest statement of commitment to health care was the passage in 1965 of Medicare and Medicaid. We took a tremendous step forward when we committed to use public money to meet the health needs of the poor, the elderly and the disabled.

The excellent health care enjoyed by Americans today, therefore, is a product of provident actions that were taken years ago--and there's need for similar action again today.

As great as our health-care system may be, there can be no debate about the glaring shortcomings that still exist. There are huge unmet health needs, felt by people in cities and rural locations across the country.

It's been widely publicized that 35 million people under age 65 in this country have no health insurance. In fact, it's been so widely publicized that perhaps we've lost our sense of shock about that number.

It's also well known that the number of uninsured has grown in recent years, and that many of the 35 million are truly middle Americans. Almost half of them have jobs.

The effects on the people themselves are already clear. It does make a difference not to have insurance. According to one recent study, the uninsured are 2-1/2 times as unlikely to have a regular source of health care and three times as likely to need some form of care as those who have insurance.

What's not as widely noticed or appreciated is that--particularly in recent years--the system has been asked to pick up the slack. In constant dollars, the amount of uncompensated care provided by hospitals grew 50 percent from 1981 to 1984. It reached a level of $6.9 billion, or an average of more than a million dollars at every hospital in the country.

It may be tempting to think this trend will somehow work itself out and go away. But it certainly won't. Nor is any other group of people or organizations in the country expected to provide a service (let alone such a vital service) without getting paid for it. How can we expect our hospitals to do so?

It may also be tempting for each party concerned with this issue to look to the others for resources and solutions. But that's not an option either.

Hospitals and other providers of health care have been working diligently during the decade of the '80s to make this nation's health dollars work harder and more productively. But there's a long way to go in that direction. The effort must continue.

Companies serving hospitals--and I put mine at the top of the list--have a major role as well. We can show, for one thing, that medical technology is not a problem but, rather, a solution. New technology can help provide better health care at a lower cost.

At both federal and state levels, the government also has a serious obligation in this matter. It must not continue to constrict eligibility and coverage levels for the poor, the elderly and the disabled. We must not try to walk away from the promises that were made to those people long ago.

Of course, private payers (including business) must uphold their obligations as well, if we continue to believe that a pluralistic health system is best for this nation. The private sector cannot shirk its role.

So there's plenty of responsibility to share, and there can be no doubt that the American people look to all of those involved to do their share.

We mustn't doubt either the high priority that Americans continue to place on health care. In a national survey commissioned by the Baxter Travenol Foundation and reported late last year, 86 percent of the people polled said that all Americans should have access to the same quality of care, regardless of ability to pay for it.

Therefore, Mr. Chairman, there are two major reasons why I favor the Minimum Health Benefits For All Workers Act.

The first is that it fits with our pluralistic approach to health care. To state that same point in a different way, it would keep some necessary health-care dollars from having to travel through Washington.

Money spent on health care works hardest when it follows the shortest possible route from the payer to the point of patient care. We should avoid side trips through government agencies whenever possible.

My second reason for a favoring the Minimum Benefits For All Workers Act is that it's progressive. It recognizes a serious need. It admits that we must act now on that need. It provides a way to improve our great system of health care not just for today but also for those who'll come after us in the years ahead.

Thank you.

The **Chairman**. I thank all of the panel members.

Mr. Crandall, let me underline one point in your testimony. Isn't there a real danger that if increasing numbers of businesses seek a competitive advantage by paring back or eliminating their health insurance coverage, we could end up destroying the private employment-based system?

Mr. **Crandall**. Well, I do not know whether we would destroy it, Senator. We would certainly weaken it. I think Mr. Maher has very aptly described the system as a tripartite system.

I think the problem that we have to be concerned about, and you mentioned in your opening remarks, is that a number of uninsured are increasing. There is in fact, not only in our industry, but in other industries, a tendency to withdraw benefits to reduce costs. Business really has no choice, and certainly a business like ours has got to be fully cost-competitive. If we are looking at cost differences of multiple hundreds of millions of dollars a year, as we are, we are going to have to rectify those.

One of two things can happen—either the employees of all companies can be covered with reasonably equivalent programs, or we and other higher-cost carriers are simply going to have to withdraw our coverage.

The **Chairman**. And that is basically what the legislation does; it provides a minimum health package.

Mr. Maher, as you know, the Chamber of Commerce is scheduled to testify later in the day. In addition to your work with Chrysler, you chair an ad hoc subcommittee appointed by the Chamber Health Care Council to review this bill, do you not?

Mr. **Maher**. That is right, Senator.

The **Chairman**. And has your committee completed its deliberations?

Mr. **Maher**. No, we have not yet.

The **Chairman**. Would you say that a number of the businesses of the Chamber committee are favorably inclined toward the legislation?

Mr. **Maher**. Well, there has certainly been lively debate, Senator, on the issue. I think the concern is, certainly on my part, that the members of the business community, particularly small companies, are not aware of what is going on; that, as we heard in Senator Thurmond's comments, a great majority of businesses, including small business, offer coverage, and I do not think they realize they are getting cost-shifted by their competitors that do not offer coverage.

The **Chairman**. You emphasize in your testimony the negative impact the current situation has on Chrysler's ability to compete in world markets. How common do you think this is among other manufacturing concerns?

Mr. **Maher**. Well, I think this is uniform, particularly on the heavy industries in the country, which are most affected by international competition. They widely offer benefits, and they are having costs shifted to them from the private sector.

The **Chairman**. Mr. Bays, as the bill moves forward, we will undoubtedly hear many voices contending that the legislation is too costly, that it will bankrupt thousands of businesses, put countless people out of work. Do you think this approach is too costly for the American economy?

Mr. BAYS. No, I do not, Mr. Chairman. I was aware of the comments made after your introductory remarks by Senator Hatch and Senator Quayle. We have looked at it very carefully at our company, and also, I am chairman of the Health Industries Manufacturers Association, which has over 300 companies, over two-thirds of which are less than $5 million in sales, so they are small businesses, and the data we have would not lead us to believe that that is a valid argument.

The CHAIRMAN. Well, we appreciate it. We will not take the time now to go into the data, but we will be in touch with you.

Mr. BAYS. Yes, we have that data, and we will be happy to give it to staff and to the Senator.

The CHAIRMAN. Thank you.

The Senator from Indiana.

Senator QUAYLE. Thank you, Mr. Chairman.

As I was listening to Mr. Crandall and Mr. Maher complain that their competitors do not offer the same health care packages that they do, I was wondering if in fact you had a minimum health benefits package as has been proposed, do your current health care packages provide more than what the Chairman is suggesting?

Mr. CRANDALL. Yes.

Senator QUAYLE. And I assume yours does, too?

Mr. MAHER. Substantially greater, right.

Senator QUAYLE. Substantially greater.

Your complaint is that your competitors do not have any, or often too low, health care coverage, and that your companies offer plans way above what the Chairman is recommending. Would it be fair to assume, then, since you want to have this mandated fair competition out there from the Federal government, that you in fact would then lower your health benefits to come down to what would be prescribed for all employers if this legislation would pass?

Would that be a reasonable conclusion?

Mr. CRANDALL. No.

Senator QUAYLE. It would not be a reasonable conclusion.

Mr. Maher.

Mr. MAHER. Not at all.

Senator QUAYLE. So in other words, there is something in between as far as what this fair competition really is and how we are going to mandate that, because there would still be a disparity. And what you are saying is that if the Kennedy bill would pass, you would still be offering more than your competitors, but not that much more, so we are only going to mandate in small increments fair competition. You are not going to get that essentially level playing field that I think you somewhat hint that you want.

Mr. CRANDALL. I doubt that the Utopian idea of a perfectly level field is going to be achieved, Senator Quayle, but I think we are going to make it more level than it is.

I think there are two or three important points. One of them is that in terms of absolute and direct costs, there will be greater parity than there is today.

Secondly, and this is a part both of the other witnesses has made is that the rub-off effect on our company and on other companies which provide full coverage will be substantially less—that is, the impact to us of being expected to make up for the coverage not provided by other companies in the form of either higher premiums, or in the form of direct subsidized payments to those institutions that——

Senator **Quayle**. What other benefits should the Federal government get into mandating to establish this level playing field that you want? Should we mandate what pension benefits should be?

Mr. **Crandall**. Yes.

Senator **Quayle**. You think that the Federal government ought to mandate that each employer must offer a pension plan to begin with, and therefore, what the benefits ought to be, that we ought to do that?

Mr. **Crandall**. That would be my view, Senator, as well as——

Senator **Quayle**. That would be your view.

Would that be your view, too, Mr. Maher, that we ought to mandate that all employers under the Fair Labor Standards Act have a pension program and what that pension program should be?

Mr. **Maher**. Senator, we are not dealing here with a ballgame that nobody is in yet. We have developed this system widely accepted by the employer community where the great majority of big and small businesses offer a plan. If you step back and look at this from a policy level, and we have been searching for years for a way to provide access to care for all Americans. And rather than come and throw it all out and say let us have some federally mandated, government-funded program, we have already had sort of a vote of all businesses, large and small, and they voted to offer health insurance. And all we are saying is there are some free riders out there, and that the people that are paying are unhappy about it.

Senator **Quayle**. Well, I am curious as to just how far we really want the Federal Government to go. Mr. Crandall says fine, we ought to establish the pensions. Is your answer yes or no?

Mr. **Maher**. I do not happen to agree with him. We already have a——

Senator **Quayle**. You do not agree. OK.

Mr. Bays, do you think that——

Mr. **Bays**. I would have no problem with the Federal government mandating pensions.

Senator **Quayle**. Mandating that all employers provide pensions and what the benefits would be; OK.

Mr. **Bays**. Yes.

Senator **Quayle**. OK. How about wages? Does Continental pay less wages to the pilots and its people than you do?

Mr. **Crandall**. Yes.

Senator **Quayle**. Should we mandate what they should pay to come up to American Airlines' standards?

Mr. **Crandall**. No. I think we have already——

Senator **Quayle**. How about halfway?

The **Chairman**. Would you let the witness finish his answer?

Senator **Quayle**. Just wait a second.

The **Chairman**. He is entitled to give a complete response to the question. That is the way this Committee is run and the way it will be run.

Mr. Crandall.

Mr. CRANDALL. Thank you, Senator.

My answer to that, Senator Quayle, would be no. We have minimum wage legislation in this country. There are major differences in employment costs between Continental and ourselves. I believe those will be worked out in the free market. I think that confrontation is going to be rather ugly. I do not think it is going to be pleasant for Eastern's customers or Eastern's employees, but it will be worked out. So to the extent that we already have minimum wage legislation, I think we have already gone into the wage arena as far as we probably need to go or ought to go at this point.

Senator QUAYLE. So in other words, your answer would be no, that we would not want to mandate what the wages ought to be beyond the minimum wage to Continental.

Mr. CRANDALL. Not beyond what we have already done; that is correct.

Senator QUAYLE. So pensions, yes; health benefits, yes; but wages, no.

Mr. CRANDALL. Wages, yes, if I may correct you. We are already there.

Senator QUAYLE. No, but should we mandate to Continental what they pay?

Mr. CRANDALL. Nor should you mandate Continental or any other explicit company with respect to either health benefits or pension benefits.

I think Mr. Maher puts it perhaps as eloquently as I have heard it put—there has been a vote, in effect, in favor of this tripartite approach. Most large- and medium-sized and small companies do offer such programs. I think it is time that we now say everybody should do so.

And if I may take the occasion to do so, I would quarrel with a point you made earlier. I think this kind of program is precisely what we need to enhance this country's international competitiveness.

If you look at what is wrong with America's international competitiveness, it is not cost; it is, in my judgment at least, the failure of management and labor to work creatively together. And this kind of program will have a favorable effect on that.

If you look at the automobile industry, for example, if I may take the opportunity to say a favorable word about what Chrysler and Ford and General Motors have done over the last few years, a much better level of cooperation between management and labor has allowed Detroit to do far better than it has done in previous years. I think this kind of program, if anything, will enhance the working together of management and labor, which we need to have.

Senator QUAYLE. I do not want to interrupt, but we are sort of pressed for time here. I have got just a couple more questions I want to get in.

But I just want to make sure that it is okay for us—under this proposal, we would mandate health benefits—and you would say it would be OK to mandate pension and pension benefits, but it would not be all right to mandate what wages should be, other than minimum wage.

Mr. CRANDALL. Right.

Senator QUAYLE. So what I am trying to do is to draw the line on how far you would like the Federal Government to involve itself into the private sector. And I think I have got your answer, and I think that is fair.

The CHAIRMAN. The Senator's time has expired.

Senator QUAYLE. OK. I can do it on the second round, or I can do it now. I have one line of quick questioning for Mr. Maher, and then I am finished.

The CHAIRMAN. The Senator is recognized.

Senator QUAYLE. Mr. Maher, is it more efficient for a family, two working spouses, male and female, with children, to buy a family plan or is it more efficient to buy a family plan for one spouse and single coverage for the other? Just in total efficiency and dollars, is it not more efficient to buy a family plan?

Mr. MAHER. I do not want to sort of waltz around your question——

Senator QUAYLE. I do not, either, because the Chair has got time sensitivities.

Mr. MAHER. All right. The point is, under this system here, where there would be an employer-based program, all we are talking about is determining how the costs are to be allocated. And the bill sets up, I think, a rather efficient way for employers to buy this coverage. And the insurance system has already developed the coordination of benefits rules so that even if you have a family policy, you can allocate the costs to the particular employer involved. We have that today.

Senator QUAYLE. But if I were under this act, my wife was working, and I had children, it would be more efficient for me to buy a family plan rather than for her to buy hers and me to buy mine——

Mr. MAHER. Sure, right.

Senator QUAYLE [continuing]. Just pure efficiency.

Well, in the legislation that you testified about, you favored requiring two-worker couples with children to purchase single coverage for one worker and family coverage for the other.

Now, by your response there, it is going to cost more. Now, obviously, in Chrysler's situation, since you have mostly married males, that would help Chrysler, but I am not so sure it will help the overall—and to go to Senator Kennedy's point up here, to reduce health care costs. What you are prescribing here and what is in this legislation will actually increase health care costs because we are mandating an inefficient purchasing of health insurance. Now, that may in fact help Chrysler, or help any employer that has a majority of married male employees, but it is not going to help others as far as the total cost.

Mr. MAHER. Well, I disagree with that, Senator. To begin with, we have a very inefficient way today in America for small businesses to buy health insurance. I think that the mechanism that would be developed through the legislation that is proposed would set up a much more efficient way for them to buy coverage. And when you combine that with the inequity of Chrysler having to pay for somebody else's employees' coverage, I think the net effect is that it is equitable for the business community, large and small, whether you employ males or females.

The **Chairman**. The Senator's time has expired.

Senator **Quayle**. OK, let me just conclude. I think the point is that we are mandating something that is inefficient, that will cost more, and as I said, it may help employers that have married male workers as a majority, but not the majority of the work force.

The **Chairman**. The Senator from Iowa.

Senator **Harkin**. Thank you, Mr. Chairman.

I just want to make one point, Mr. Chairman, since I support the legislation.

I just want to point out that there may be a small thing that I would like to discuss on this bill, and that is the elimination under the bill of benefits for alcoholism and drug dependency. I am concerned that the bill as written might encourage this. They are not specifically required under the sections relating to covered services, Title III. While such treatments are not prohibited, I am concerned that any wording which would provide Federal permission for employers to exclude this benefit might be a dangerous precedent.

I am just concerned about not specifically putting in alcoholism and drug dependency.

The **Chairman**. If the Senator would yield, as I mentioned, this is a bare-bones program. It is not the Cadillac; it is the small Ford. And we do not include mental health programs. I wish we could include mental health, and I wish we could do the drug provision. But we will examine the practicality of adding these benefits once we start loading the bill up unduly, I think we are finished.

We provide in the bill the possibilities for expansion, and I would be very hopeful that we could get it. But if we are going to try and thread this needle—and I think it is a needle—I think we will probably have to go—we will have a chance to debate this, Senator. I know how strongly you feel about it. But this is the dilemma that we are in, and I am very mindful of the strong feelings you have on those programs, which I share, and we have worked very closely together. But this is part of our dilemma.

Senator **Harkin**. Well, as I said, I basically support the bill. I just am concerned about that area.

And then the one other area that I am concerned about, and I would like to ask all three of the gentlemen here, the bill covers full-time employees; it covers all business entities, and there were, I think, some very good provisions in there that help small business, some really good provisions in there. But again, when you look at what is happening out there in our economy, one of the fastest-growing sectors of our economy is part-time workers.

Generally speaking, those part-time workers are some of those who may need health care benefits the most. They are women, usually with young children; they are low-income people who are working in the service sector of our economy, which is really growing very rapidly, and they are putting in a few hours a week on part-time jobs.

Now, I understand that you have to draw a line someplace, and maybe you cannot cover everyone. But do any of you have any thoughts or suggestions on how we might reach this sector, because it is large; it is not small. It is a large group of people out there.

How do you reach this sector of our society who are working on these part-time jobs?

Mr. **Crandall**. Senator, let me first start with a statement that will reveal my ignorance. I was under the impression that the bill does cover any employee who works 17½ hours or more per week.

Senator **Harkin**. Yes, that is right.

Mr. **Crandall**. OK. You are talking now about going below that level, below the 17½ hours a week?

Senator **Harkin**. That is right. I am talking about those who may work three hours a day, for example.

Mr. **Crandall**. I would only make this point. We have many part-time employees in the airline business. And when I say many, 20, 22 percent of our employees are now part-time, that is, less than a full work week.

As we looked at this legislation, we thought the 17½-hour standard was a generous one, because very, very few of those people work less than 17½ hours a week. The effect in our particular case, since we do provide full health care for part-time people, is that the per-hour cost of health care coverage for part-timers is substantially greater than the per-hour cost for full-timers, since the number of hours across which the cost of coverage is amortized is far less.

I do not have an answer to your question. I have not thought about the issue, how it might be driven down below 17½ hours. I think this bill will provide coverage, certainly at least in our universe, for almost 100 percent of our part-time people.

Senator **Harkin**. Well, again, I point out that we do not——

Mr. **Bays**. Senator, I might just comment, we hire very few part-time workers, but I have thought about the problem, and I thought the 17½-hour adequately covered the part-time workers.

Data that I have seen—and it is not really hard data, but I think it is pretty reliable—indicates that the people who work less than 17½ hours, or 20 hours per week, really do that by choice, and they are usually a spouse and they have coverage one way or another—not everybody, obviously. But I would be reluctant to see us go below the 17½ hours.

Senator **Harkin**. Well, again, I think there are some of those who maybe are getting——

Mr. **Bays**. Yes, but to get back to the Chairman's point earlier, I really think to start loading this up with other bells and whistles would slow it down.

Senator **Harkin**. I am also looking ahead. You may have a small business out there that would be covered generally speaking, but that might say, well, the health care benefits costs are going to cost us so much more, so instead of employing these people 30 hours a week, we will employ them 15 hours a week.

Mr. **Bays**. And that may well happen, but it is happening to a greater degree now.

Senator **Harkin**. So you are saying that 17½ hours per week basically, you think is sufficient.

Mr. **Bays**. That is what we feel, yes.

Senator **Harkin**. Well, thank you, Mr. Chairman.

The **Chairman**. I agree with the Senator's concern about those groups. It is a common concern. But I think the point is that, as we pointed out, again it is more costly for the part-time workers, and there is some question as to how far down can we go. And I am hopeful that we can see some expansion in terms of the Medicaid provisions that would help to meet some of these concerns.

Senator **HARKIN**. If I might just add, Mr. Chairman, we get this situation where someone is on Title XIX on Medicaid, a young woman with a couple of children, and they get a part-time job to try to get off welfare. And they just get above that income level, and now they do not have Medicaid, now they do not have health care coverage. There are a lot of people out there like that, and I just want to express that as a concern that I have and to see if any of you have any thoughts on it, that is all.

The **CHAIRMAN**. We do assure, Senator, that anybody who is on welfare and takes a job of more than 17½ hours per week is covered completely. That is more than a million people.

Senator **HARKIN**. Oh, I did not know that. I am sorry. I missed that.

The **CHAIRMAN**. Yes. If they are on welfare, and they take a job of more than 17½ hours, then they qualify. This provision picks those people up.

Senator **HARKIN**. That is right, yes.

The **CHAIRMAN**. So that is what we have tried to do, because we have recognized that health care costs are such a major factor in terms of maintaining people on welfare. And this affects about 400,000 people in the country.

We have not accepted on this Committee the "early bird" rule. We are still running by the old seniority system around here. And I see the Senator from Vermont here, and we will recognize him.

Senator **STAFFORD**. Thank you, Mr. Chairman.

I guess I would be recognized as "old seniority," not "early bird," this morning.

I have spent the last hour and a half in the Veterans' Affairs Committee, listening to the very depressing story there on AIDS, so I have come from that hearing to this one with some impression of the necessity for health care in this country.

I have no questions of this panel; maybe I will of the next one.

The **CHAIRMAN**. Fine. Thank you very much.

The Senator from South Carolina.

Senator **THURMOND**. Thank you, Mr. Chairman.

I want to congratulate you gentlemen for doing what you are doing with your companies and for all that you are doing for your employees.

I am concerned about a lot of the little companies that are not as successful as yours—maybe they do not have as good management or do not have the financing or whatnot. And I am just wondering, wouldn't this bill have a greater impact on small business than big business?

Mr. **MAHER**. Well, first off, it is obviously going to have an impact on a firm that does not offer insurance. However, that firm would have the comfort of knowing that its competitors would be equally affected by this bill.

Mr. **CRANDALL**. Senator, I do not know—I obviously do not have the benefit of experience working in a small business. I cannot imagine, however, that the net effect on a small business or a medium-sized business is going to be greatly different than it is for a major corporation. The cost of providing medical coverage is a per-hour cost. It will increase costs; it will require that that firm's revenues be adjusted to recognize those costs.

But as my colleague points out, so long as all businesses with which that business competes are faced with exactly the same level of costs, it is difficult to see how that is going to have a tremendously detrimental effect.

It is important to recognize, I think, that this is not a balance sheet issue; it is not a resource issue. It is a day-to-day cost of doing business. For the small- and medium-sized business, it is truly an insured program. For large companies like my own and like Chrysler, it is essentially a pay-as-you-go program.

But yes, it will change the businesses' costs, but so long as all costs change at the same rate, it is hard for me to see how it is going to have a tremendously adverse impact on them.

Senator **Thurmond**. I remember a few years ago—I have been in the Senate a good while—when Chrysler was really in trouble. You got a new head of the organization, and he has done a wonderful job, and he is a very able, fine man. But all businesses do not have people like that, especially some of the small businesses. And I am just wondering how they are going to stay in business if we are going to burden them with a lot of things.

And there is no question in my mind that once you get the foot in the door with this bill, next year, or in just a few years, there will be efforts to expand, just like the minimum wage—it keeps expanding, expanding. Everything the government has gone into, I do not know of any shrinking that has taken place; it has all been expansion.

So I was just wondering if you big businessmen—and you are big businessmen; you represent companies worth not millions, but billions, and you represent companies here that are some of the biggest in America. But what about these little companies that cannot bear all this expense and cannot stay in business if they have to compete with things of that kind?

Mr. **Maher**. Well, Senator, let us take a dry-cleaning establishment. If the cost of dry-cleaning a suit as a result of this bill goes up a dime because that is what it is going to take for the dry-cleaner to recover his cost in his particular market, obviously, the cost of this gets spread across society. But I submit first off, the dry-cleaner, if he increases his costs by a dime, is not going to have a Korean dry-cleaner come in and set up shop or start doing business. If somebody comes in internationally and sets up shop in the United States, they are going to be covered by this bill, but they are not going to be impacted by foreign competition. But if the price of dry-cleaning a suit goes up as a result of this, I submit that is a fairer way of spreading the cost than is currently going on in this country.

The same thing with a fast-food hamburger.

Mr. **Bays**. Senator, may I just add to that that I understand the concern that you and Senator Quayle have about where do we stop; the Federal government is getting into another essential service, and we are taxing people—it is a hidden tax, but it is in fact a tax—and I generally find myself in agreement with that attitude.

But I really believe this is an essential social service, and I do not see that if we do this for 35, 37 million Americans, whatever it is, that we necessarily then have to start having the Federal Government get involved in all kinds of other activities.

I would agree with the four points here as far as the benefits for the business and economy, and I generally find myself in agreement with Dan Quayle, but I just disagree with him on the points he made. I do think it makes fair competition, in the points that have been made, for small business as well as large, and on and on.

So I share your concern about having the Federal Government, and as I said in my testimony, one of the benefits of this Act as I see it is that it does not have to come through Washington to get back to the recipient. I like that, and I would hope that we could keep that in the bill. And I do not necessarily think it follows that everything that comes along, you are going to end up passing a bill to mandate benefits or wages or whatever.

Senator THURMOND. It is fair competition for the Federal Government to mandate the same cost of doing business for all companies?

Mr. MAHER. This bill, of course, does not do that, Senator. It sets a minimum standard. And I think that probably—and I am not sure of this—but I would suggest that probably the majority of companies that offer coverage exceed the coverage that is mandated by this bill.

I mean, we have not seen as a result of the minimum wage all companies in America reducing their wage rates to the minimum wage level just because there happens to be a minimum wage law in the country. I do not think you are going to see that as a result of the adoption of this bill.

Mr. BAYS. Senator, that is one of the points about the big business/small business, it seems to me. I doubt that you will find any of the three companies represented at this table changing their health benefits, all of which I am sure far exceed the mandated benefits within this bill.

So we are going to still pay more, or have benefits that far exceed what the small companies will be providing. Small companies generally either service large companies or compete with each other. And it is not in our interest—we are a large distributor, for example, of health care products. We have over 2,000 manufacturers that we distribute for. It is not in our interest to see those companies go under, but it is also not in our interest to see foreign competition and others come in who do not provide any benefits.

Our surveys show that roughly 70 percent of those companies do provide health benefits, but the other 30 percent, we feel, should. And as a matter of fact, if this bill does not pass, we are thinking about making that part of our negotiating structure with those people who supply us.

Senator THURMOND. Opportunity is what people want, and I am wondering if people can go and organize a business to start with on a small scale, if they are going to be burdened down with so many requirements of the Federal Government.

I like to think about this country as a country of opportunity, where you can start and get bigger and bigger. And you all are already big; you are worth billions. But what about these people who want to go in business on a small scale and increase as time goes by, by producing a good product or a quality product? I am just concerned about the Federal Government laying so many requirements on everything.

Mr. **Bays**. I can only speak for the health industry, but Senator Hatch said earlier that there are other costs that the Congress could do something about that are far more onerous on the health care companies than this legislation.

He mentioned malpractice insurance. I could add to that product liability insurance. The difficulty in getting and keeping product liability insurance for a small entrepreneurial health care company is far more onerous, infinitely more onerous, on that entrepreneur than anything we are talking about here today. And there are ways that the Congress could do something about that, but never seems to get around to it.

So I really just do not think we should zero in on the health care act here. We should look at all the costs that the small companies have.

Senator **Thurmond**. Those are not start-up costs, of course.

Mr. **Bays**. Yes, they are, in many, many cases. One of the great things about the health care industry is that it is still an industry where an entrepreneur, a tinkerer, if you will, can go out in his garage or her garage, come up with a product that is life-saving, life-prolonging, or that cuts costs in health care and can live the dream that you are talking about. It is an industry that technology is actually the lifeblood of it. And the innovation and the lifeblood and the technology come from the small companies, not from the big companies.

Senator **Thurmond**. In order to provide opportunity, our government has laid aside certain contracts for small business, showing that they just cannot compete with big business, big business like you all are. And certain contractors are laid aside every year for small business. They recognize that.

I am just deeply concerned about the Federal Government going into every facet of people's lives and mandating what they do. And I wonder if we are going to lose this country of opportunity which was founded by our forefathers and under which we made such greatness.

Thank you, Mr. Chairman.

The **Chairman**. You have raised some interesting points about the cost factor in terms of the health industry. We would like to explore those further with you at some time. We are open-minded on it. We run into jurisdictional questions, and I was just visiting with staff about some of those things. But I would be very interested in hearing your ideas, to see what could be done that might make some sense. We know on some of these issues, the Congress has been reluctant to act, but there may be some areas that we could explore and see what the results are.

It has been enormously interesting for me, and we appreciate all of your help and look forward to keeping in touch with you.

Senator **Harkin**. Mr. Chairman.

The **Chairman**. Excuse me. Senator Harkin.

Senator **Harkin**. Mr. Chairman, I wonder if I could just indulge the Committee just for a second.

The **Chairman**. Sure.

Senator HARKIN. I just want to say, completely off this subject, to Mr. Crandall, I have been reading what you have been saying about the congestion at our airports and the problem there, and I just want to commend you for taking an enlightened and very strong position on that. I think you are absolutely on the right track, and we have got to do something about that, and your comments and the position you have taken are to be commended.

Mr. CRANDALL. Thank you, sir. If I may take the opportunity to say so, I made a speech yesterday at a Safety Conference at Northwestern University, and I will send you a copy. I continue to think we need to move quickly to do something. That is entirely off the subject.

Senator HARKIN. Thank you.

The CHAIRMAN. That is all right. Send me a copy, too. We might even put it in the record. [Laughter.]

Thank you all very, very much.

Our next panel consists of two distinguished union leaders—Owen Bieber, President of the UAW. Although he sits across the bargaining table from Chrysler, Ford and GM, he shares many of the same concerns about international competitiveness. Also, John Sweeney, President of Service Employees International. Many of the people he represents or seeks to organize are those who have the most difficulty securing adequate health benefits from their employers.

We welcome both of you, and we will start off with you, Mr. Bieber.

STATEMENT OF OWEN BIEBER, PRESIDENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, AFL-CIO, CLC, WASHINGTON, DC, ACCOMPANIED BY BILL HOFFMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UAW; AND JOHN J. SWEENEY, INTERNATIONAL PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC, WASHINGTON, DC, ACCOMPANIED BY PEGGY CONNERTON, CHIEF ECONOMIST

Mr. BIEBER. Thank you, Mr. Chairman.

I have here with me to my right, Bill Hoffman, who is Director of our Social Security Department at UAW.

Mr. Chairman, we have submitted a full statement with you and the Committee, and we would ask that that be made a part of the record, and let me be brief and try to give you my oral statement this morning.

I am President of the International Union. I appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW appreciates the opportunity to present our views on the proposed Minimum Health Benefits for All Workers Act of 1987, S. 1265. And we strongly endorse this legislation, which would assure that all American workers and their families have access to needed health care services.

We want to commend you, Mr. Chairman, and we would also commend Senator Weicker, the cosponsor, for your effective leadership in addressing one of the most serious social problems facing this Nation—the lack of health care insurance for millions of working Americans and their families.

An astounding 16 percent of the population, or 37 million Americans, lack health insurance coverage. Significantly, about three-quarters of them are working men and women and their dependents.

Although the majority of employers, including large and small businesses, provide their workers with health insurance protection, a significant and growing minority do not. We believe that this bill would accomplish two major objectives.

First, by guaranteeing that all American workers and their families have at least a minimum package of health insurance benefits, the bill would improve access to needed medical services and thus improve the health of millions of Americans.

Secondly, the bill would sharply reduce the unnecessary, inefficient, and unfair cost-sharing that takes place under our present health care system. This would lead to substantial savings for the Federal Government and to the majority of employers who do provide health insurance coverage.

The impact of cost-shifting between employers is significant to the industrial sector of our economy, which commonly provides health insurance for its workers. The industrial sector is already under considerable pressure as a result of inefficient and misdirected trade and economic policies.

In contrast, employers who do not provide any health care protection generally are not faced with pressure from international competition. Manufacturing companies are subsidizing employers in other sectors through the shifting of these health care costs.

If the Congress is serious about taking steps to increase the competitiveness of our industrial base, it must reduce the unfair shifting of health care costs by requiring every employer to pay the health insurance benefits for its own workers.

To accomplish the twin objectives of expanding access to health care and reducing unfair cost-shifting, we believe it is essential that three basic elements be retained in the legislation.

One, all employers must be required to provide the minimum package of health insurance benefits. There cannot be any exceptions for small business. Nor is it sensible simply to mandate benefits for employers choosing to offer health care plans. Such proposals do not address the fundamental problem created by employers who manage to avoid offering any health coverage at all.

Second, all employees, including part-time employees, must be covered under their employers' health care plans. Third, spouses and dependent children must also be covered.

The UAW supports most other provisions of the bill. We also recognize that some elements will require further refinement, and we look forward to working with this Committee on that.

We recognize that some may criticize the legislation as being anti-business. That is simply not true. The overwhelming majority of employers who currently offer health insurance benefits to their workers will not have to shoulder any additional burdens under the bill. In fact, they will enjoy significant cost savings by virtue of the reduction in cost-shifting among employers, the preemption of State-mandated benefit laws, and the establishment of the regional insurers who will offer insurance coverage at a more affordable rate.

Mr. Chairman, let me conclude by stating that as essential and commendable as this legislation is, we must all recognize that it is not a panacea for all the health care problems facing our Nation including, for example, the loss of health care protection when workers lose their jobs due to plant closings or layoffs, and the loss of health insurance coverage by retirees when companies file for bankruptcy. These and other problems can be met only by a universal and comprehensive national health insurance plan.

As you know, Mr. Chairman, my predecessors as President of the UAW have been leaders in the fight for a national health insurance program. I remain committed to this struggle, and I am confident that it will be won. Although that objective continues unchanged, we recognize that we have an opportunity at the present time to begin to promote greater access to health care. That is why the UAW is committed to work in support of the legislation that you have introduced. It will assure access to basic health care services for all working Americans and their families.

Thank you very much.

The CHAIRMAN. Thank you very much, Mr. Bieber.

[The prepared statement of Mr. Bieber follows:]

June 24, 1987

Statement of

Owen Bieber
President
International Union, UAW

on the

subject of

THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987 (S. 1265)

before the

Committee on Labor and Human Resources
U. S. Senate

On behalf of:
International Union, United Automobile,
Aerospace & Agricultural Implement
Workers of America, UAW

Mr. Chairman, my name is Owen Bieber. I am President of the International Union, UAW. I appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW appreciates the opportunity to present our views on the proposed "Minimum Health Benefits For All Workers Act of 1987" (S. 1265). We strongly endorse this legislation, which would assure that all American workers and their families have access to needed health care services. We commend you, Mr. Chairman, and Senator Weicker, for your effective leadership in addressing one of the most serious social problems facing this nation: the lack of health insurance coverage for millions of working Americans and their families.

THE NEED

While the United States continues to be a world leader in advancing modern medicine, a substantial portion of the population lacks access to even the most basic health care services. Today, an astounding 16 percent of the population — 37 million Americans — lack health insurance coverage. Fifty million persons are without health insurance coverage for at least part of the year.

Significantly, about three quarters of the persons without health insurance coverage are working men and women and their dependents. Although the majority of employers, including both large and small businesses, provide their workers with health insurance protection, a significant and growing minority of employers do not provide any health insurance benefits.

The UAW continues to believe that all American citizens should be entitled to health insurance coverage as a basic social right. But certainly, at a minimum, there is no reason why any person who is employed, or his or her dependents, should be without this essential protection. Our society has already made a determination all employers should be required, as a condition of doing business, to provide all employees with a minimum wage, protection against unemployment (through Unemployment Insurance), and basic retirement and disability insurance (through Social Security). The UAW believes it is time for this country to take the next logical step and require all employers to provide at least a minimum package of health insurance benefits to all their workers and their dependents. That is why we strongly support the proposed "Minimum Health Benefits for All Workers Act of 1987" (S. 1265).

The UAW believes that this legislation would accomplish two major objectives. First, and most importantly, by guaranteeing that all American workers and their families have at least a minimum package of health insurance benefits, the bill would significantly improve access to needed medical services and thereby improve the health of millions of Americans. Because they lack health insurance coverage, too many families presently do not have access to adequate health care services. Too often they are forced to postpone or do without needed medical care because limited family income must be used for food, housing, or other basic needs. Their dilemma is vividly demonstrated by the fact that the absence of health insurance has been linked with higher mortality rates in general, and with higher rates of infant mortality in particular. In addition, being uninsured encourages individuals to rely on hospitals (primarily public hospital emergency rooms) for medical treatment, instead of using preventive and other types of more cost-effective medical services.

Second, the bill would sharply reduce the unnecessary, inefficient, and unfair cost-shifting that takes place under our present health care system. This would lead to substantial savings for the federal government. Under present law, some of the workers and their dependents who do not receive health insurance protection from their employers wind up being covered by Medicare, Medicaid, or CHAMPUS. The proposed legislation would require their employers to provide the primary health insurance coverage, and would necessarily reduce expenditures under the federal health care programs.

Similarly, the bill would provide relief to the majority of private and public employers who currently provide health insurance coverage to their own employees. Under present law, uninsured persons usually wind up being treated as uncompensated care by hospitals and other health care providers. The cost of providing this "uncompensated care" is not fully absorbed by hospitals and other health care providers. Instead, it is passed on to other private payors, mostly other employers, who already are providing health care protection.

In addition, in the situation where a worker does not receive any health insurance coverage from his or her employer, but the worker's spouse is employed by another company that does offer health insurance benefits, the worker will often enroll in the health care plan offered by the spouse's employer. In such cases, the health care costs associated with the worker are directly shifted from one employer to the other.

The UAW submits that both types of cost-shifting between employers are unfair. This country does not allow employers to opt out of paying Social Security taxes and to shift the cost of providing basic retirement benefits onto other employers. There is no reason why some employers should be allowed unfairly to shift the cost of providing basic health protection for their employees to other businesses.

The UAW is particularly concerned about the impact of this cost-shifting between employers on the industrial sector of our economy. The businesses in this sector, which are already under considerable pressure as a result of ineffective and misdirected trade and economic policies, commonly provide health insurance for their workers. In contrast, employers who do not provide any health care protection tend to be in the growing service sector of our economy, which generally is not faced with pressure from international competition. Thus, the fact is that manufacturing companies have been subsidizing employers in the service sector through the shifting of health care costs. Surely there cannot be any justification for continuing this massive cross-subsidy. If Congress is serious about taking steps to restore the competitiveness of our industrial base, one important measure would be to reduce the unfair shifting of health care costs by requiring every employer to pay for health insurance benefits for its own workers.

To accomplish the twin objectives of expanding access to health care and reducing unfair cost-shifting, the UAW believes it is essential that three basic elements be retained in the legislation.

* All employers must be required to provide the minimum package of health insurance benefits to their workers. There cannot be any exceptions for small businesses. Nor is it sensible simply to mandate benefits for employers choosing to offer health care plans. Such proposals do not address the fundamental problem created by employers who manage to avoid offering any health coverage at all (and indeed, may exacerbate that problem, by encouraging some employers to cancel existing health care plans).

- All workers (including part-time employees working 17.5 hours or more per week) must be covered under their employers' health care plans.

- The health care plans provided by employers must also provide coverage for spouses and dependent children. This important pro-family feature is already contained in more progressive employee benefit plans, such as major UAW negotiated health care plans.

There are many other features of the proposed legislation which the UAW strongly supports. But we also recognize that some elements will require further refinement.

The UAW supports the provision of the bill that would preempt all State laws requiring health insurance plans to offer specific benefits or to include particular types of health care providers. Most existing state mandated benefit requirements do not enhance the quality of medical care. Instead, they operate mainly to line the pockets of various health care providers. These state mandated benefit laws greatly complicate the administration of health plans for large, national employers. They also add significantly to the cost of health insurance for both large and small employers. And in some cases, they undermine efforts by employers and unions to institute effective managed care and other cost containment programs which promote competition among medical care providers and thereby hold down increases in health care costs.

The UAW supports the provision in the legislation which allows employers to satisfy their obligations by providing a package of benefits which is actuarially equivalent to the value of the health benefit program specified in the legislation. This approach allows a reasonable degree of flexibility in benefit design, avoids unnecessary nitpicking of decent employee benefit plans, and provides some opportunity to tailor programs to meet the needs of specific groups of workers. Furthermore, the provision would allow the vast majority of employers currently providing health insurance benefits to meet requirements of the legislation without having to amend existing benefit plans.

The UAW also supports the provision in the bill prohibiting denial of benefits for pre-existing conditions. Full coverage for these conditions has traditionally been characteristic of progressive health care plans, such as the major UAW negotiated benefit plans.

The UAW believes that the minimum benefit package proposed in the bill should be improved. In particular, we are concerned that the employee cost-sharing features -- the level of the deductibles, co-insurance, and "stop-loss" provisions -- may be so high as to present obstacles to needed care for many workers. These high out-of-pocket costs could mean potential bankruptcy for many low wage workers. The UAW is also disappointed that medically necessary mental health care is specifically excluded from the bill. Discrimination against persons whose health care problem is mental, rather than physical, is simply not appropriate in our judgment.

The UAW recognizes that the benefits specified in the legislation are only intended as a minimum standard, not a comprehensive benefit package. Through collective bargaining, unions and employers would be free to negotiate supplemental coverage to address specific unmet needs or to enhance benefits above the minimum statutory requirement. That is an appropriate role for collective bargaining, rather than relying on such bargaining to be the engine for generating a reasonable minimum level of basic health care protection for the entire nation.

The UAW is troubled by the provisions of the bill that would allow employers to require workers to pay part of the premiums for the minimum health care coverage. We believe that employers should be required to pay for 100% of the premium cost. However, the UAW commends the sponsors of the legislation for at least providing protection for low wage workers, by requiring employers to pay the entire premium cost for workers whose hourly wage is $4.19 or less. To avoid a "cliff" which would lead to unintended, harmful results, this extra protection should at least be gradually phased out for persons with wages above this level.

The UAW also commends the sponsors of the legislation for including provisions which would create regional insurers who would be able to offer the minimum benefit package at lower cost due to economies of scale and other factors. Many small businesses currently have to pay exhorbitant rates and administration charges for health insurance coverage. This provision will allow them to obtain such coverage at a more affordable cost. We also endorse the concept that these regional insurers would fix premiums under a community rating system applicable to all employers participating in such arrangements. Some caution is necessary to assure that "better risk" groups do not opt out of insurance coverage.

The UAW is troubled by the provision in the bill that would allow employed children to "waive" enrollment in the health plans offered by their own employers, as long as they continued to be covered under health plans provided by their parents' employers. We believe this provision will give employers an incentive to lay off older workers and hire teenagers in their places. It will also permit some employers, particularly businesses in the service sector employing a high percentage of teenagers, to continue to shift health care costs onto other employers. The UAW is also concerned about the provision in the bill that would allow a worker to waive enrollment in a health care plan for the worker's dependents if they are already covered under another employer's health care plan. To minimize unfair cost-shifting, we believe some mechanism should be worked out to spread the cost of covering dependents fairly among all employers.

The UAW commends the sponsors of the legislation for including a provision prohibiting employers from discriminating against an employee or prospective employees because they have spouses and/or dependent children. That prohibition will help prevent undermining of the pro-family intent of the legislation.

Finally, the UAW applauds the fact that the bill includes provisions that will promote cost containment and quality assurance programs. The bill would require the regional insurers to take certain measures towards these objectives, while permitting employers and unions providing coverage through other mechanisms to devise suitable cost containment and quality assurance mechanisms of their own.

The UAW looks forward to working with the sponsors of the bill on many of these matters as it moves forward in the legislative process. We believe we can work together to shape a program which would represent one of the most significant pieces of social legislation in the second half of the twentieth century.

We recognize that some persons may criticize the legislation as being "anti-business". That is simply not true. The overwhelming majority of employers who currently offer health insurance benefits to their workers will not have to shoulder any additional burdens under the bill. In fact, they will enjoy significant cost savings by virtue of the reduction in cost-shifting among employers, the preemption of state mandated benefits laws, and the establishment of the regional insurers who will be able to offer insurance coverage at more affordable rates.

As previously indicated, the UAW strongly opposes any effort to "carve out" small businesses from this bill. This would undermine the twin objectives of promoting broader access to health care and reducing unfair cost shifting among employers. However, we are willing to explore the feasiblity of tax incentives which could be targeted at those small businesses that truly require assistance.

Some opponents of the legislation have objected to the notion of the federal government "mandating" employee benefits. But clearly there is ample precedent for the federal government to take such action. Our society has already mandated that employers provide a minimum wage, contribute to minimum retirement income, disability insurance and basic protection against loss of income due to layoffs (through Social Security and Unemployment Insurance). We have also imposed minimum occupational health and safety and pension funding standards on employers. In line with these precedents, it is now time for the federal government to mandate all employers to provide a minimum level of health insurance protection for workers and their families.

I would like to emphasize, Mr. Chairman, that the approach adopted by this legislation is essentially a private sector solution. The bill does not call for increased government expenditures. In fact, it would save money for the federal government. The legislation basically seeks to require the private sector to step up to the responsibility of providing adequate health insurance protection to workers and their families. There is no justification for letting employers escape from this fundamental responsibility. To allow a small minority of employers to continue to evade this responsibility is unfair to the federal government, to other employers, as well as to workers and their families.

Mr. Chairman, let me conclude by stating that, as essential and commendable as this legislation is, we must all recognize that it is not a panacea for all of the health care problems facing our nation. Specifically, the bill does not address the problems associated with:

- the loss of health insurance protection when workers lose their jobs due to plant closings or layoffs;
- the loss of health insurance coverage by retirees when companies file for bankruptcy;
- the often inadequate and uneven quality of health care rendered to individuals;
- continuing medical care inflation;
- the shortages of doctors in many rural areas and inner cities;
- discrimination against the elderly, the poor, women and minorities in securing needed health services;
- shorter life spans of the poor and minorities; and
- infant mortality rates in many U. S. cities comparable to those found in many Third World counties.

These problems can be met only by a universal and comprehensive national health insurance plan. With the exception of South Africa, the United States is the only industrialized nation without a national health plan. Individuals in Canada, Great Britain, Sweden, West Germany, Italy and other countries are guaranteed basic health care protection by law. American citizens should also have this same protection by law as a basic social right.

As you know, Mr. Chairman, my predecessors as President of the UAW have been leaders in the fight for a national health insurance program. I remain committed to this struggle, and I am confident that it will be won. Although that objective continues unchanged, we recognize that we have an opportunity at the present time to begin to promote greater access to health care. That is why the UAW is committed to work in support of the legislation you have introduced, which would at least assure access to basic health care services for all working Americans and their families.

Again, Mr. Chairman, the UAW applauds the leadership that you have consistently provided in efforts to achieve a more equitable and effective health care system. I am enormously pleased to note that we are once again talking about making social progress in this country -- about taking public action against serious national problems that individuals may be powerless to overcome. For the past several years, we have had to struggle to simply hang on to past gains. I believe that Washington is beginning to realize that the American people are eager to go forward again. This legislation can be an important part of the response.

We look ahead to working with you and the other sponsors of S. 1265 as it moves forward in the legislative process. We urge the Members of this Committee and the Congress to give this legislation prompt, favorable consideration.

Thank you.

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The **CHAIRMAN**. President Sweeney, we are glad to have you here.

Mr. **SWEENEY**. Mr. Chairman and Members of the Committee, I am John Sweeney, President of the Service Employees International Union. I am accompanied by Peggy Connerton, our Chief Economist.

I am happy to have the opportunity of testifying on behalf of Senate Bill 1265, the Minimum Health Benefits for All Workers Act of 1987.

More and more employers are failing to provide basic health insurance for their workers. This legislation would correct that failing for 24 million of our citizens who are employed, but who currently are uninsured.

This bill is in a long tradition of uniquely American solutions that rely on setting minimum standards for private enterprise rather than providing comprehensive coverage through government programs.

In this regard, it is no different than other minimum standards for employers provided by statute—the 40-hour work week, unemployment insurance, the minimum wage, Social Security.

Until recently, we had been making progress toward providing decent health through employment-based health insurance. But for the past few years, we have been moving backwards. More than 37 million Americans, one in six, now have no health coverage. That is an increase of 50 percent in 6 years. This presents a terrible burden for our health care system.

The financial cost of caring for the uninsured totaled $7.6 billion in 1985. Our public hospitals are filled to overflowing with uninsured patients dumped from other facilities.

All of this comes at a time when our public insurance programs have been hard-hit by cutbacks in Federal funding.

Ironically, 75 percent of the uninsured are people who are working and their families. And since the working poor are not eligible for Medicaid coverage in most States, they face strong barriers to medical care.

Our Union recently conducted a health care survey of our low-wage members that were most likely to be uninsured—clericals, janitors, nurses' aides, and food service workers—at 27 different worksites in 11 different States.

Those 500-plus respondents are typical of what is being called the "new work force". Eighty-two percent of them were female, working at a median hourly wage of $4.31 an hour. These were union workers, workers more likely to be offered health insurance by their employers.

But over half of them still do not have health coverage from any source. The survey also showed that where workers did have coverage, they could not afford to cover their children. Half the insured workers with children in our sample did not have a family plan.

Who bears the cost of health care for these working Americans who have no coverage? The public bears the cost, subsidizing employers who refuse to provide coverage.

Over 55 percent of uninsured workers use emergency rooms or public clinics as their primary source of medical care. S. 1265 provides a partial answer to the problem and would help us end this ridiculous subsidy of employers.

Employers have been required by law since 1938 to pay a minimum wage. It is time they provide minimum health coverage. This bill would bring essential health care to nearly all of America's working family. It would produce substantial savings in administrative fees and public subsidies. It would introduce significant economies of scale into the health care system.

Small businesses will benefit from more fair competition and cheaper health insurance premiums.

What do the voters think about this bill?

We just finished taking a poll last week, a national sample of more than 700 registered voters. That poll found that Americans, by a 4-to-1 margin, support minimum standards of pay and benefits. Moreover, 68 percent of the registered voters in our survey favor requiring employers to offer and pay for at least 80 percent of the cost of health insurance.

S. 1265 is reasonable. It is in keeping with longstanding American traditions. It would help small business. It would end the public subsidy of employers. But most important, it will bring health protection to the millions of working families who are not insured.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Sweeney. I hope you would make that poll available. I know that no Members of this Committee are ever influenced by polls, but it might be useful to show it to some of our colleagues.

Mr. SWEENEY. That poll will be available to the Committee, as will the survey on access to health care, which we have also referred to.

The CHAIRMAN. Fine. We welcome it.

[The prepared statement of Mr. Sweeney follows:]

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TESTIMONY OF

SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

BEFORE

THE HONORABLE EDWARD M. KENNEDY
CHAIR

COMMITTEE ON LABOR & HUMAN SERVICES
U.S. SENATE

JUNE 24, 1987

SUBMITTED BY:

JOHN J. SWEENEY
INTERNATIONAL PRESIDENT

SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

TESTIMONY OF
JOHN J. SWEENEY
ON BEHALF OF
THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC
"THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT 1987" (S. 1265)

I AM JOHN SWEENEY, PRESIDENT OF THE 850,000 MEMBER SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO AND CHAIRMAN OF THE AFL-CIO'S HEALTH CARE COMMITTEE. ON THEIR BEHALF, I WELCOME THIS OPPORTUNITY TO COMMENT ON S. 1265, THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987.

I SPEAK TODAY IN SUPPORT OF A STRONG EFFORT TO HOLD BACK THE TIDE THAT CURRENTLY LEAVES MILLIONS OF WORKERS AND THEIR FAMILIES WITHOUT HEALTH INSURANCE. S. 1265 REPRESENTS A SIGNIFICANT STEP TOWARDS ASSURING ACCESS TO ESSENTIAL HEALTH CARE FOR EVERY WORKING FAMILY IN AMERICA.

MORE AND MORE EMPLOYERS ARE FAILING TO PROVIDE BASIC HEALTH PROTECTION -- SOMETHING WHICH USED TO BE PART OF THE ACCEPTED COST OF DOING BUSINESS. THIS LEGISLATION WILL CORRECT THAT FAILING FOR MORE THAN 24 MILLION OF OUR CITIZENS -- TWO-THIRDS OF ALL THE CURRENTLY UNINSURED.

THIS INCLUDES MANY OF SEIU'S LOW-WAGE MEMBERS -- JANITORS, CLERICALS, NURSES AND HOME HEALTH AIDES -- WHO WOULD RECEIVE HEALTH BENEFITS FOR THE FIRST TIME. OTHER SEIU MEMBERS WOULD SEE LOWER HEALTH COSTS -- AS RESPONSIBLE EMPLOYERS NO LONGER ARE FORCED TO PICK-UP THE TAB FOR BUSINESSES THAT FAIL TO PROVIDE HEALTH COVERAGE.

SOME WILL SAY THIS BILL IS TOO FAR-REACHING, EVEN DESCRIBING IT AS A BACK-DOOR WAY TO NATIONAL HEALTH INSURANCE. TO THE CONTRARY, IT'S A UNIQUELY AMERICAN SOLUTION TO SOCIAL PROBLEMS THAT RELIES ON SETTING MINIMUM STANDARDS FOR PRIVATE ENTERPRISE, RATHER THAN ON PROVIDING COMPREHENSIVE COVERAGE THROUGH GOVERNMENT PROGRAMS.

IN THIS REGARD, IT'S NO DIFFERENT FROM OTHER MINIMUM STANDARDS OF EMPLOYMENT DETERMINED BY STATUTE -- THE 40 HOUR WORK WEEK, UNEMPLOYMENT INSURANCE, THE MINIMUM WAGE, AND SOCIAL SECURITY.

THIS BILL IS A GOOD FIRST STEP TOWARD A NATIONAL PROGRAM TO PROTECT AMERICANS FROM THE TRAGEDY THAT LACK OF HEALTH INSURANCE BRINGS. FAILING TO INSURE AMERICA'S WORKING FAMILIES IS A NATIONAL RECIPE FOR PAIN AND THE SKYROCKETING COST OF PUBLICLY PROVIDED CURATIVE MEDICINE.

WE SHARE YOUR SENSE OF URGENCY AND SO ASK FOR ITS PROMPT CONSIDERATION AND PASSAGE, WITH WHATEVER MODIFICATIONS ARE APPROPRIATE.

THE REST OF MY TESTIMONY WILL FOCUS ON: (1) THE ROLES PLAYED BY THE "NEW" SERVICE ECONOMY AND COST CONTAINMENT PRESSURES IN THE WORSENING CRISIS IN ACCESS TO HEALTH SERVICES; (2) AN SEIU SURVEY OF OUR LOW-WAGE MEMBERS AND THE OBSTACLES THEY FACE TO OBTAINING ACCESS TO AFFORDABLE HEALTH CARE; AND (3) THE COSTS AND BENEFITS TO BUSINESSES OF PROVIDING MINIMUM HEALTH CARE BENEFITS.

WIDENING GAPS IN MEDICAL COVERAGE

UNTIL RECENTLY, OUR SOCIETY HAD BEEN MAKING STEADY PROGRESS TOWARD THE GOAL OF PROVIDING DECENT, AFFORDABLE HEALTH CARE FOR ALL OF US -- PRIMARILY THROUGH EMPLOYMENT BASED HEALTH INSURANCE. TWO FEDERAL PROGRAMS -- MEDICARE AND MEDICAID -- FILLED THE GAPS IN MEDICAL CARE FOR THE NON-WORKING ELDERLY AND POOR.

BUT FOR THE PAST FEW YEARS, WE HAVE BEEN MOVING BACKWARDS. YEARS OF PROGRESS TOWARDS COMPREHENSIVE, EMPLOYER-PROVIDED HEALTH INSURANCE FOR WORKERS AND THEIR FAMILIES HAVE BEEN STOPPED COLD AND A STEADY EROSION IN THE NATION'S PRINCIPLE SOURCE OF COVERAGE HAS BEEN UNDER WAY.

THE STARK REALITY IS THAT AMERICANS ARE LOSING THEIR HEALTH INSURANCE. MORE THAN 37 MILLION PEOPLE -- ONE IS SIX -- NOW HAVE NO HEALTH COVERAGE, AN INCREASE OF 50 PERCENT IN SIX YEARS. AND AS

MANY AMERICANS HAVE COVERAGE CLEARLY INADEQUATE TO PROTECT THEM FROM MEDICAL OR FINANCIAL CATASTROPHE. ONE THIRD OF THE UNINSURED ARE CHILDREN, OUR NATION'S MOST PRECIOUS RESOURCE.

THE GROWING NUMBER OF UNINSURED AND UNDERINSURED FACE STRONG OBSTACLES TO OBTAINING HEALTH CARE WHEN THEY NEED IT. WHILE MANY FIND MEDICAL CARE BY ONE MEANS OR ANOTHER, THIS CARE IS USUALLY BOTH TOO LITTLE AND TOO LATE.

THOSE UNINSURED WHO MANAGE TO GET INTO THE HEALTH CARE SYSTEM OFTEN END UP IN THE HOSPITAL EMERGENCY ROOM. THE FINANCIAL BURDEN FOR THE UNINSURED TOTALLED $7.6 BILLION IN 1985. OUR PUBLIC AND VOLUNTARY HOSPITALS ARE FILLED TO OVERFLOWING WITH UNINSURED PATIENTS "DUMPED" FROM OTHER FACILITIES.

IN 1986, MORE THAN 12 PERCENT OF ALL AMERICANS -- NEARLY 15 MILLION PEOPLE -- NEEDED MEDICAL CARE BUT HAD DIFFICULTY GETTING IT. ONE MILLION PEOPLE TRIED TO OBTAIN CARE, BUT COULD NOT AFFORD IT.

PUBLIC INSURANCE PROGRAMS , THE SUPPLEMENT TO EMPLOYMENT-BASED INSURANCE, HAVE BEEN HARD HIT BY THE RECENT SERVICE CUTBACKS IN FEDERAL FUNDING . FEDERAL BUDGET CUTS HAVE REDUCED THE PROPORTION OF POOR AMERICANS ELIGIBLE FOR MEDICAID TO 43%, DOWN FROM 63% IN 1975. MEDICARE PATIENTS NOW PAY OVER HALF OF THEIR MEDICAL BILLS OUT-OF-POCKET, AN INCREASE OF MORE THAN ONE-THIRD OVER WHAT THEY WERE PAYING IN 1980

BUT THE BIGGEST THREAT TO UNIVERSAL HEALTH CARE IS THE BREAKDOWN OF HEALTH COVERAGE AT THE WORKPLACE. TODAY, SEVENTY-FIVE PERCENT OF UNINSURED AMERICANS ARE WORKERS OR THEIR DEPENDENTS. MORE THAN TWO-THIRDS LIVE IN FAMILIES OF FULL-TIME, FULL-YEAR WORKERS. SINCE THE WORKING POOR ARE NOT ELIGIBLE FOR MEDICAID COVERAGE IN MOST STATES, THEY FACE STRONG FINANCIAL BARRIERS TO OBTAINING MEDICAL CARE.

THIS SHOCKING LACK OF ACCESS TO HEALTH CARE BY MANY WORKERS HAS PREDICTABLE CONSEQUENCES IN HUMAN TERMS. ONE SEIU UNION MEMBER, FRANCES KENNEDY, HAS A SICK HUSBAND SUFFERING FROM MULTIPLE CIRCULATORY AND HEART PROBLEMS AND SEVERE EPILEPSY. SHE WORKS FULL-TIME AS A NURSE AIDE AT WHARTON NURSING HOME IN TENNESSEE FOR ABOUT $4.00 AN HOUR WITH NO HEALTH COVERAGE. HER HUSBAND'S SERIOUS ILLNESS HAS COST THEM THEIR HOME AND ALL THEIR POSSESSIONS. AT THIS POINT, SHE DOESN'T KNOW WHAT TO DO. EVERYTHING IS GONE.

TWO OTHER SEIU WORKERS TESTIFIED AT AN EARLIER HEARING OF THIS COMMITTEE ON THEIR HARDSHIPS. MORE AND MORE WORKERS ARE EXPERIENCING SIMILAR TRAGEDIES. PRIVATE INSURANCE COVERAGE IS SHRINKING DRAMATICALLY BECAUSE OF THE TREND TOWARD A SERVICE ECONOMY AND BECAUSE EMPLOYERS' EFFORTS TO CONTROL COSTS HAVE ALL TOO OFTEN FOCUSED ON SHIFTING THEM TO WORKERS, NOT ON MANAGING COSTS AT THE WORKSITE.

THE "NEW" SERVICE ECONOMY MEANS DECLINING HEALTH COVERAGE

OUR ECONOMY IS UNDERGOING DRAMATIC CHANGE, AND EMPLOYEE HEALTH CARE IS BEING LOST IN THE TRANSITION.

ECONOMIC TRENDS POINT TO A STILL ERODING MANUFACTURING BASE, WHERE MOST EMPLOYEES HAVE HEALTH INSURANCE, AND A SWITCH TO A SERVICE ECONOMY, WHERE COVERAGE IS HARDER TO COME BY.[1]

ACCORDING TO A 1987 STUDY BY THE EMLOYEE BENEFITS RESEARCH INSTITUTE (EBRI), 60% OF UNINSURED WORKING AMERICANS WORK IN RETAIL TRADE AND OTHER SERVICE JOBS. THREE QUARTERS OF THE 16.5 MILLION UNINSURED WORKERS MAKE LESS THAN $10,000 A YEAR. NEARLY TWO-THIRDS OF THEM LIVE IN FAMILIES WITH ANNUAL INCOMES BELOW $20,000, WHICH IS NEAR THE MEDIAN FAMILY INCOME LEVEL.

THIS HIGH CONCENTRATION OF THE UNINSURED POPULATION AMONG LOW-PAID SERVICE WORKERS AND THEIR DEPENDENTS MEANS THAT THE PROBLEM WILL NOT DISAPPEAR, BUT LIKELY GROW WORSE.

ALREADY, SERVICE JOBS HAVE INCREASED A HEFTY 17% SINCE 1980, WHILE MANUFACTURING SHRUNK BY 2.4 MILLION JOBS.

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[1] A 1985 HHS STUDY FOUND THAT 4.8% OF MANUFACTURING WORKERS WERE UNINSURED ALL YEAR COMPARED TO 16% IN THE FAST-GROWING PERSONAL SERVICES FIELD. (THE EMPLOYED UNINSURED AND THE ROLE OF PUBLIC POLICY, BY MONHEIT, ET. AL.)

AND A RECENT JOINT ECONOMIC COMMITTEE STUDY SHOWS THAT MORE THAN TWO OUT OF EVERY FIVE NEW JOBS CREATED SINCE 1980 PAY UNDER $7,000. THE NEW REALITY IS FAST-GROWTH AMONG JOBS AND INDUSTRIES THAT PAY LOW WAGES AND OFFER FEW, IF ANY, BENEFITS.

COST SHIFTING TO WORKERS MEANS DECLINING HEALTH COVERAGE

AS CONSUMERS, WE ARE ALL CONCERNED BY SKYROCKETING HEALTH BILLS. THE LABOR MOVEMENT OPPOSES MEDICAL PRICE INCREASES SEVEN TIMES GENERAL INFLATION AND THE HIGH LEVEL OF RESOURCES -- 10.7% OF GROSS NATIONAL PRODUCT -- NEEDED JUST TO PROVIDE THE BARE MINIMUM OF HEALTH SERVICES, NEVER MIND THE UNIVERSAL CRADLE-TO-GRAVE COVERAGE OTHER COUNTRIES ENJOY.

BUT WE HAVE LONG ARGUED THAT THE CURRENT HEALTH COST CONTAINMENT APPROACH, ONE THAT DEPENDS ON UNFETTERED COMPETITION, WOULD SACRIFICE ACCESS TO HEALTH CARE BOTH NOW AND IN THE LONG RUN.

THE REASON IS SIMPLE: COMPETITION USES ABILITY TO PAY AS ITS MECHANISM TO PRODUCE EFFICIENCY AMONG PROVIDERS AND CONSUMERS. SO EMPLOYERS SEEK TO SLASH MEDICAL BILLS BY SHIFTING COSTS TO EMPLOYEES TO ENCOURAGE THEM TO MAKE MORE EFFICIENT USE OF MEDICAL SERVICES. BUT THOSE HIGHER DEDUCTIBLES AND CO-PAYS MAKE IT LESS LIKELY THAT LOW-WAGE WORKERS SEEK ANY MEDICAL TREATMENT, AND PRICE HEALTH INSURANCE TOTALLY OUT OF REACH FOR MANY.

UNFORTUNATELY, YESTERDAY'S PREDICTIONS ARE TODAY'S REALITY. THE HEALTH COST CRISIS OF THE EARLY 1980s HAS SPAWNED THE HEALTH COVERAGE CRISIS OF THE MID-DECADE.

EMPLOYER AFTER EMPLOYER HAS COME TO THE BARGAINING TABLE DEMANDING THAT WORKERS PICK UP A PORTION OF HEALTH PREMIUMS OR SACRIFICE COVERAGE. THESE COST CONTAINMENT MEASURES LEAVE WORKERS DANGEROUSLY UNDERINSURED OR CAUSE THEM TO DROP COVERAGE ALTOGETHER.

THE PROPOSALS TO SHIFT COSTS TO EMPLOYEES HAVE NOT BEEN RESTRICTED TO RELATIVELY WELL-PAID INDUSTRIAL WORKERS, EITHER. INDEED, MUCH OF OUR RECENT COLLECTIVE BARGAINING EFFORTS HAVE GONE INTO MAINTAINING CURRENT HEALTH COVERAGE.

FOR EXAMPLE, WE RECENTLY UNDERTOOK A MAJOR CAMPAIGN AGAINST HILLHAVEN -- A MAJOR NURSING HOME CHAIN -- WHICH CAME TO THE BARGAINING TABLE WITH A PROPOSAL TO MAKE NEW HIRES PAY HALF OF THEIR HEALTH PREMIUMS FOR THE DURATION OF THEIR EMPLOYMENT. WE EXPOSED THE FACT THAT THESE CUTS DID NOT ARISE OUT OF HIGHER COSTS BECAUSE UTILIZATION HAD NOT CHANGED ADVERSELY. IN THE END, WE HELD THE LINE ON HEALTH PREMIUMS.

AND WE HAVE EVEN MANAGED TO EXPAND COVERAGE IN SOME CASES. DISTRICT 925 IN OHIO CHANGED THE DEFINITION OF ELIGIBILITY FOR THE CUYAHOGA PUBLIC LIBRARY'S HEALTH PLAN FROM 20 TO 16 HOURS, THUS IMPROVING ACCESS BY LOW-WAGE CLERICAL WORKERS.

AND WE JUST GOT STATE FUNDING COVERING HEALTH BENEFITS FOR 16,000 MASSACHUSETTS HOME HEALTH WORKERS (15,000 OF THEM ARE NON-UNION). UNTIL THIS VICTORY, THESE WORKERS, THE MAJORITY OF WHOM ARE LOW-INCOME, FEMALE AND MEDICAID INELIGIBLE, HAD BEEN COUNTED AS PART OF THE 600,000 UNINSURED PEOPLE IN MASSACHUSETTS.

HOWEVER, FOR EVERY VICTORY, THERE HAVE BEEN SETBACKS. AND THIS TREND IS NOT RESTRICTED TO OUR WORKERS. NATIONWIDE, RECENT STUDIES OF PRIVATE HEALTH PLANS SHOW 300% INCREASES IN DEDUCTIBLES OVER THE LAST COUPLE OF YEARS.

MOREOVER, RECENT SURVEY DATA REVEAL THAT INCREASED COST-SHARING HAS WON ONLY LIMITED IMPROVEMENTS IN THE WAR AGAINST HIGH COSTS AND AT AN ENORMOUS PRICE IN DECREASED COVERAGE FOR LOWER INCOME WORKERS. A 1985 EQUITABLE LIFE ASSURANCE SOCIETY SURVEY OF EMPLOYER HEALTH PLAN STRATEGIES FOUND THAT COST-SHARING CAUSES LOWER-WAGE WORKERS EARNING APPROXIMATELY $15,000 A YEAR TO USE LESS SERVICES. BUT SIMILAR LEVELS OF COST-SHARING HAD NO EFFECT ON THE USE OF HEALTH CARE SERVICES BY WORKERS MAKING $30,000 OR MORE.

SEIU'S ACCESS TO HEALTH CARE SURVEY

SEIU RECENTLY CONDUCTED A HEALTH CARE SURVEY OF OUR LOW-WAGE MEMBERS -- MAINLY CLERICALS, JANITORS, NURSE AIDES, AND FOOD SERVICE WORKERS -- AT 27 WORKSITES IN 11 STATES. THE PURPOSE WAS TO TARGET THE WORKING POPULATION MOST LIKELY TO BE UNINSURED ON THE JOB (I.E., SERVICE WORKERS MAKING LESS THAN $10,000 A YEAR) TO EXAMINE THEIR ACCESS TO AND UTILIZATION OF MEDICAL SERVICES.

THEY ARE TYPICAL OF SERVICE WORKERS -- MEMBERS OF THE "NEW ECONOMY" WE READ SO MUCH ABOUT. THE 541 RESPONDENTS ARE MOSTLY FEMALE (82%). THEY EARN SLIGHTLY MORE THAN THE MINIMUM WAGE (THEIR MEDIAN HOURLY WAGE IS $4.31). MOST (70%) WORK FULL-TIME AND ENJOY FEW BENEFITS.

ONE DIFFERENCE: AS UNION WORKERS, THEY WERE MORE LIKELY TO BE OFFERED HEALTH INSURANCE ON THE JOB COMPARED TO SERVICE WORKERS GENERALLY. STILL, DESPITE AGGRESSIVE BARGAINING BY THEIR LOCAL UNIONS TO SECURE COVERAGE, 39% HAD NO WORKPLACE HEALTH COVERAGE.

AND ALTHOUGH 61% OF THE EMPLOYEES ARE OFFERED SOME HEALTH INSURANCE, OVER HALF THE SAMPLED WORKERS (53%) STILL DON'T HAVE HEALTH COVERAGE FROM ANY SOURCE. NEARLY 69% OF THESE UNINSURED WORKERS HOLD FULL-TIME JOBS.

MANY WORKERS DON'T TAKE THE EMPLOYER'S HEALTH PLAN BECAUSE THEY CAN'T AFFORD THE PREMIUMS. OTHERS FIND THE PLAN TO BE SO GROSSLY INADEQUATE THEY CHOOSE TO GO WITHOUT. LOOKING MORE CLOSELY AT THE HEALTH PLANS WITH LOW PARTICIPATION RATES, THREE COMMON BARRIERS TO AFFORDABLE HEALTH COVERAGE EMERGE:

FIRST, HIGH EMPLOYEE CONTRIBUTIONS FOR FAMILY COVERAGE, AVERAGING $130 A MONTH; SECOND, HEAVY UPFRONT DEDUCTIBLES AVERAGING $500 FOR FAMILY COVERAGE; AND THIRD, NO COVERAGE FOR PHYSICIANS' SERVICES.

THE SURVEY ALSO SHOWED THAT WHERE WORKERS HAVE COVERAGE, THEY OFTEN DO NOT EARN ENOUGH TO COVER THEIR CHILDREN. ROUGHLY HALF OF THE INSURED WORKERS WITH CHILDREN IN OUR SAMPLE DO NOT HAVE THE FAMILY PLAN. THIS PERCENTAGE RISES TO 83%, WHERE THE WORKERS THEMSELVES ARE UNINSURED.

THIS FINDING CORRESPONDS TO NATIONAL STATISTICS SHOWING THAT 29% OF THE 11 MILLION UNINSURED CHILDREN LIVE IN FAMILIES HEADED BY PARENTS WITH EMPLOYER-BASED HEALTH COVERAGE.

OUR SURVEY FURTHER SHOWED THAT AFFORDABILITY IS A MAJOR FACTOR IN THE DECISION OF WORKING PARENTS TO PURCHASE FAMILY COVERAGE. INSURED WORKERS WHO NEED FAMILY COVERAGE REVEALED THAT THEY WOULD PAY $10.77 EVERY TWO WEEKS OR NEARLY 5% OF THEIR AFTER-TAX

INCOME TO COVER THEIR CHILDREN. CURRENT SAMPLE PLANS PRICE FAMILY COVERAGE AT A RATE EQUAL TO ABOUT 29% OF THESE WORKERS' AFTER-TAX EARNINGS. UNINSURED WORKERS WOULD BE WILLING TO PAY $11.83 EVERY TWO WEEKS, AN AMOUNT ALSO EQUAL TO 5% OF THEIR AFTER-TAX INCOME TO GET DECENT HEALTH INSURANCE.

ALSO STRIKING IS THE HEAVY PUBLIC SUBSIDIES OF EMPLOYERS WHO FEEL NO RESPONSIBILITY TO PROVIDE HEALTH COVERAGE. UNINSURED WORKERS RELY MORE HEAVILY ON THE HOSPITAL EMERGENCY ROOM (26% OF UNINSURED WORKERS) AND PUBLIC CLINICS (29% OF UNINSURED WORKERS) AS THEIR PRIMARY SOURCES OF MEDICAL CARE. BY CONTRAST, THE INSURED WORKERS OVERWHELMINGLY (61%) HAVE PERSONAL DOCTORS FOR ROUTINE CARE. ALSO, 8% OF THE INSURED WORKERS IN OUR SAMPLE ARE ON MEDICAID, THE PUBLIC INSURANCE PROGRAM.

NOT SURPRISINGLY, UNINSURED WORKERS IN THE SAMPLE OFTEN DO NOT SEEK MEDICAL CARE, BECAUSE OF ITS HIGH COST. OVER 41% OF THEM SAID THEY CAN NOT AFFORD TO SEEK MEDICAL ASSISTANCE OR HAVE BEEN TURNED AWAY.

THE SURVEY'S MESSAGE IS SIMPLE: LOW-WAGE WORKERS NEED ACCESS TO AFFORDABLE, DECENT HEALTH COVERAGE.

S. 1265 PROVIDES STRONG MEASURES TO IMPROVE ACCESS TO CARE

S. 1265 FILLS THE BIGGEST HOLE IN THE NATION'S HEALTH CARE SYSTEM, COVERING 24 MILLION WORKING AMERICANS OUT OF THE 37 MILLION UNINSURED POPULATION. IT REQUIRES THAT EVERY WORKING AMERICAN HAVE ACCESS TO AT LEAST A MINIMUM PACKAGE OF HEALTH INSURANCE COVERAGE.

EMPLOYERS HAVE BEEN REQUIRED BY LAW SINCE 1938 TO PAY A MINIMUM WAGE. IT'S TIME TO INSIST THAT THEY PROVIDE AT LEAST MINIMUM HEALTH INSURANCE TOO.

SEIU STRONGLY ENDORSES THE BILL'S BASIC BENEFITS. IT'S A PATH TO HEALTH PROTECTION FOR MILLIONS OF LOW-INCOME WORKING AMERICANS. IT DOES NOT MEAN CADILLAC COVERAGE OF HEALTH EXPENSES. IT DOES MEAN COVERAGE OF NECESSARY HOSPITAL CARE WITHOUT AN ANNUAL LIMIT ON DAYS OF CARE, DOCTORS' BILLS, DIAGNOSTIC TESTS, PRE-NATAL AND WELL-BABY CARE, AND IT MEANS PROTECTION AGAINST THE FINANCIAL BURDEN OF CATASTROPHIC MEDICAL EXPENSES.

WE ALSO SUPPORT THE BILL'S BROAD COVERAGE OF EMPLOYEES (I.E., THOSE WORKING 17.5 HOURS A WEEK OR MORE). PART-TIMERS AND THEIR DEPENDENTS MAKE UP 17% OF THE UNINSURED WORKERS, EQUAL TO THEIR WORKFORCE REPRESENTATION. MOREOVER, NOT COVERING THEM WOULD

CREATE POWERFUL ECONOMIC INCENTIVES TO REPLACE FULL-TIME WORKERS WITH PART-TIMERS TO AVOID PARTICIPATION. THIS RUNS COUNTER TO THE GOAL OF BROAD ACCESS TO CARE THROUGH THE WORKPLACE.

WHILE SOME EXCEPTIONS MAY BE NECESSARY (E.G., FOR SUMMER WORKERS), WE SUPPORT 17.5 WEEKLY HOURS AS THE GENERAL CUTOFF POINT. THIS THRESHOLD PICKS UP 77% OF THE PART-TIME, PART-YEAR WORKERS WITH NO HEALTH COVERAGE. ALSO, THIS THRESHOLD MAKES IT DIFFICULT FOR EMPLOYERS TO AVOID COVERAGE BY SHUFFLING HOURS OF WORK. JOBS CANNOT BE EASILY SUBDIVIDED BELOW THIS LEVEL WITHOUT ENCOUNTERING SERIOUS INEFFICIENCIES. FINALLY, THE 17.5 WEEKLY HOURS CUTOFF IS CONSISTENT WITH COBRA'S NEW DEFINITION OF PART-TIME WORK FOR PURPOSES OF COMPLYING WITH NON-DISCRIMINATION RULES UNDER ERISA.

THIS BILL ALSO PROMISES RELIEF FOR LOW-WAGE WORKERS, BY REQUIRING EMPLOYERS TO PICK UP THE FULL CONTRIBUTION FOR THOSE EARNING LESS THAN $4.19 AN HOUR. A 1987 EBRI STUDY SHOWS THAT OVER HALF OF THE UNINSURED WORKERS EARN LESS THAN 125% OF THE MINIMUM WAGE AND WOULD BENEFIT FROM THIS PROVISION. OUR SURVEY HIGHLIGHTED THE DIFFICULT CHOICES THAT LOW-WAGE WORKERS FACE IN PAYING RENT, FOOD AND OTHER ECONOMIC NECESSITIES OR THEIR MEDICAL BILLS.

HOWEVER, WE URGE YOU TO CONSIDER USING AN ANNUAL EARNINGS FIGURE RATHER THAN AN HOURLY RATE TO DETERMINE WHICH EMPLOYERS PAY THE FULL PREMIUM. THIS WOULD COVER PART-TIMERS WHO EARN MORE

THAN $4.19 HOURLY, BUT BELOW POVERTY WAGES OVER THE YEAR. FOR EXAMPLE, $4.19 AN HOUR COULD BE CONVERTED TO AN ANNUAL EARNINGS FIGURE OF $8,380, BASED ON A 40 HOUR WEEK, 50 WEEKS A YEAR.

A SECOND CONCERN IS THE POTENTIAL MONETARY LIABILITY TO WORKERS UNDER THE BILL'S MINIMUM HEALTH PLAN -- APPROXIMATELY $3,500 A YEAR. ON TOP OF THE $30 AVERAGE MONTHLY PREMIUMS FOR FAMILY COVERAGE, EMPLOYEES FACE $500 IN ANNUAL DEDUCTIBLES AND A $3,000 MAXIMUM ON OUT-OF-POCKET PAYMENTS. WHILE THE OVERALL DOLLAR PACKAGE SEEMS REASONABLE, OUR SURVEY RESULTS SHOWED THAT DEDUCTIBLES IN THE $500 RANGE FOR FAMILY COVERAGE ARE A BARRIER TO LOW-WAGE WORKERS SEEKING OUT MEDICAL CARE. OUR BETTER HEALTH PLANS COVERING LOW-WAGE WORKERS GENERALLY HAVE $100 INDIVIDUAL AND $300 FAMILY DEDUCTIBLES.

NATIONALLY, BENEFIT SURVEYS SHOW THAT LOWER DEDUCTIBLES WOULD CONFORM MORE WITH GENERAL STANDARDS. FOR EXAMPLE, THE DEPARTMENT OF LABOR'S 1986 EMPLOYEE BENEFITS SURVEY SHOWED 63.6% OF EMPLOYEES IN PLANS WITH SPECIFIED DEDUCTIBLES WERE COVERED BY PLANS WITH INDIVIDUAL DEDUCTIBLES LESS THAN $200.[2] WE SUGGEST THAT THE

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[2] OTHER STUDIES SHOW SIMILAR RESULTS. THE WYATT COMPANY'S 1986 GROUP BENEFITS SURVEY OF 1,400 EMPLOYERS REPRESENTING MEDIUM AND LARGE WORK ESTABLISHMENTS IN THE PUBLIC AND PRIVATE SECTOR REPORTS THAT THE MAJORITY OF EMPLOYERS (66%) PROVIDING COMPREHENSIVE MEDICAL PLANS HAVE INDIVIDUAL DEDUCTIBLES OF LESS THAN $200. SEE ALSO A PROFILE OF GROUP MAJOR MEDICAL EXPENSE INSURANCE IN THE UNITED STATES, CONDUCTED BY THE HEALTH INSURANCE ASSOCIATION OF AMERICA, 1984.

COMMITTEE LOOK FOR POSSIBLE WAYS TO REARRANGE THE BILL'S MINIMUM BENEFIT PACKAGE TO LOWER DEDUCTIBLES, WHILE KEEPING AVERAGE CONTRIBUTION RATES THE SAME.

FINALLY, THE BILL WOULD REQUIRE WORKERS COVERED BY OTHER SOURCES OF INSURANCE -- 26% IN OUR SAMPLE -- TO NOW TAKE THE EMPLOYER'S HEALTH PLAN. THIS PROVISION COULD INCREASE HEALTH COSTS, (I.E., THE WORKING SPOUSE WOULD NOW PAY MONTHLY PREMIUMS AND A $250 INDIVIDUAL DEDUCTIBLE).

OF COURSE, STANDARD COORDINATION OF BENEFITS (COB) PROVISIONS WORK TO MITIGATE THESE COSTS. THESE COB PROVISIONS SET RULES TO AVOID PAYING CLAIMS TWICE BECAUSE OF DUAL COVERAGE.

WE WOULD RECOMMEND AGAINST A PROVISION REQUIRING WORKERS TO TAKE THE EMPLOYER'S PLAN, EVEN IF THEY ARE COVERED UNDER THEIR SPOUSE'S PLAN. AT THE VERY LEAST, YOU COULD REQUIRE THAT THE MORE GENEROUS PLAN ALWAYS PAY FIRST. (UNDER CURRENT RULES, THE EMPLOYER'S PLAN OR THE BIRTH DATE OF HUSBAND AND WIFE USUALLY DETERMINE WHICH PLAN IS THE PRIMARY PAYOR.)

WHILE WE HAVE FOCUSED ON AREAS FOR IMPROVEMENT, THERE CAN BE NO DOUBT THAT THIS LEGISLATION IS NEEDED TO ASSURE BASIC ACCESS TO ESSENTIAL HEALTH CARE FOR ALL WORKING FAMILIES.

COSTS AND BENEFITS TO BUSINESSES

WHILE THE BILL DOES CARRY A PRICE TAG OF $20 BILLION, THE COSTS ARE SPREAD OUT ACROSS MANY EMPLOYERS, AND COME TO ABOUT $.40 AN HOUR ON AVERAGE. BASED ON MINIMUM WAGE STUDIES, THIS LABOR COST INCREASE (WHICH IS ABOUT A 10% INCREASE IN THE MINIMUM WAGE) WOULD HAVE NO DISCERNIBLE IMPACT ON PRICES OR UNEMPLOYMENT.

OF COURSE, SUCH MODELS DO NOT CAPTURE THE DISTRIBUTIONAL EFFECTS OF IMPOSING NEW MINIMUM STANDARDS -- ESPECIALLY THE ECONOMIC IMPACTS ON SMALLER BUSINESSES. HOWEVER, THE BILL TAKES A NUMBER OF POSITIVE MEASURES TO HELP SMALL BUSINESSES COMPLY WITH THE NEW STANDARDS.

WE ESTIMATE THAT 48% OF ALL UNINSURED WORKERS ARE IN FIRMS WITH FEWER THAN 25 EMPLOYEES. MANY OF THESE BUSINESSES NOW FACE PROHIBITIVE PRICES FOR HEALTH POLICIES, WITH ADMINISTRATIVE CHARGES THAT CAN GO AS HIGH AS 50% OF THE TOTAL PREMIUMS.

S. 1265 CREATES REGIONAL INSURANCE POOLS FROM WHICH SMALL FIRMS CAN PURCHASE HEALTH INSURANCE AT CHEAP RATES. THE LARGE-SCALE OF THESE REGIONAL POOLS IS EXPECTED TO PRODUCE SUBSTANTIAL SAVINGS IN ADMINISTRATIVE COSTS -- WITH REDUCTIONS OF 10%-35% OVER THE CURRENT SYSTEM.

MOREOVER, SMALL BUSINESSES CAN TAKE ADVANTAGE OF THE CAPITATED OPTIONS TO BE OFFERED -- PREFERRED PROVIDER ORGANIZATIONS (PPO'S) AND HEALTH MAINTENANCE ORGANIZATIONS (HMO'S). UTILIZATION OF HMO'S, PPO'S AND OTHER CAPITATED ARRANGEMENTS COULD SHAVE OFF ANOTHER 15% IN CONTRIBUTION COSTS.

THE MAJORITY OF SMALL BUSINESSES (25 EMPLOYEES OR LESS) THAT ALREADY INSURE THEIR WORKERS -- ALMOST 60% OF EMPLOYEES IN SMALL FIRMS -- CAN ALSO REAP SUBSTANTIAL ADMINISTRATIVE SAVINGS BY SWITCHING TO THESE REGIONAL INSURANCE POOLS THAT WILL PROVIDE HEALTH INSURANCE TO SMALL BUSINESSES.

OUR OWN EXPERIENCE WITH MULTI-EMPLOYER TRUSTS SUGGEST SUBSTANTIAL SAVINGS ARE POSSIBLE. MOST RECENTLY, SMALL LOCAL GOVERNMENTS IN THE BAY AREA IN CALIFORNIA WORKED TOGETHER WITH LABOR TO SET UP THE ASSOCIATION OF BAY AREA GOVERNMENTS' (ABAG) NEW BENEFIT TRUST. ABAG POOLS BAY AREA LOCAL GOVERNMENT HEALTH PLANS AND OFFERS HEALTH BENEFITS AT LOWER PRICES WITH BUILT-IN COST CONTAINMENT FEATURES, (E.G., A PREFERRED PROVIDER NETWORK OF HOSPITALS). PREMIUM COSTS HAVE DROPPED 20% SINCE ABAG STARTED, WHILE IMPROVING ACCESS FOR GOVERNMENT EMPLOYEES.

FROM MY PERSPECTIVE, PERHAPS THIS BILL'S MOST IMPORTANT BENEFIT TO SMALL BUSINESS IS THE "LEVEL PLAYING FIELD" IT PROVIDES ON WHICH ALL EMPLOYERS CAN FAIRLY COMPETE. WE REPRESENT SERVICE WORKERS IN

HIGHLY COMPETITIVE INDUSTRIES WITH LARGE NUMBERS OF SMALL EMPLOYERS. THE PAY SCALE IS LOW, BUT WE HAVE MANAGED TO SECURE HIGHER WAGES AND BENEFITS.

MANY SMALL EMPLOYERS WANT TO PROVIDE FOR THE HEALTH OF THEIR WORKERS, BUT FEAR THEY WILL BE PLACED AT A SEVERE "COMPETITIVE" DISADVANTAGE IN THE MARKETPLACE. THEY FACE UNFAIR COMPETITION FROM EMPLOYERS WHO WOULD PASS OFF THEIR HEALTHCARE RESPONSIBILITIES TO THE PUBLIC AND OPERATE AT THE LOWEST COMMON DENOMINATOR -- THE MINIMUM WAGE AND NO HEALTH BENEFITS.

IN THOSE CITIES WHERE SEIU HAS MASTER AGREEMENTS WITH BUILDING OWNERS AND MANAGERS COVERING MOST OF THE INDUSTRY, THE SMALLER CLEANING COMPANIES HAVE BEEN ABLE TO ABSORB THE COSTS, TO PROSPER AND TO GROW. SMALL CLEANING COMPANIES CAN OFFER HEALTH COVERAGE WITHOUT FEAR OF BEING UNDERCUT AND COMPETE AGAINST EACH OTHER BASED SOLELY ON EFFICIENCY. THAT'S WHY SMALL CLEANING CONTRACTORS CAN AFFORD TO PAY $.80 AN HOUR IN CHICAGO AND $.68 AN HOUR IN NEW YORK CITY FOR DECENT HEALTH COVERAGE.

AND WHAT EXCUSE DO GIANT CORPORATIONS HAVE THAT FAIL TO INSURE THEIR WORKERS? ONE-QUARTER OF UNINSURED WORKERS ARE AT FIRMS WITH 1,000 OR MORE EMPLOYEES. COSTS ARE NOT THE BURNING ISSUE. NOR IS FOREIGN COMPETITION.

THE SAD REALITY IS THAT MORE AND MORE EMPLOYERS ARE STEADFASTLY REFUSING TO LIVE UP TO THEIR OBLIGATIONS TO PROVIDE DECENT HEALTH COVERAGE. THEY ARE THE "FREE RIDERS" -- LETTING BUSINESSES WHO INSURE THEIR WORKERS PAY TOO MUCH BECAUSE THEY PAY TOO LITTLE.

IT'S TIME TO PUT THOSE COSTS WHERE THEY BELONG -- ON THE SHOULDERS OF THE MINORITY OF BUSINESSES THAT REFUSE TO PROTECT THEIR WORKERS' HEALTH.

FINALLY, ANY COSTS TO BUSINESSES MUST ALSO BE BALANCED AGAINST SIGNIFICANT SAVINGS TO INDIVIDUALS, INDUSTRY AND SOCIETY.

EMPLOYEES WHO NOW CARRY PRIVATE INSURANCE OR PAY LARGE OUT-OF-POCKET BILLS WILL SAVE MONEY -- $3.5 BILLION A YEAR ALONE TO INDIVIDUALS WHO DROP THEIR NON EMPLOYMENT-BASED POLICIES AND PICK-UP INSURANCE AT GROUP RATES.

THE HOSPITAL INDUSTRY WILL HAVE LESS UNSPONSORED CARE BECAUSE MORE WORKERS WILL BE INSURED. AS THE ATTACHED CHART SHOWS, THESE SAVINGS COULD ACCOUNT FOR ABOUT ONE-HALF OR MORE OF THE HOSPITALS' $7.6 BILLION IN CHARITY CARE.

FINALLY, SOCIETY BENEFITS BY LOWERING THE HEALTH CARE EXPENSES FOR THE UNINSURED. CURRENTLY, OUT-OF-HOSPITAL SERVICES AND PRIMARY CARE REMAIN UNCOVERED AND INACCESSIBLE TO LOW-INCOME WORKERS, WHO OFTEN POSTPONE CARE UNTIL THEY ARE SEVERELY ILL.

ALLOWING PEOPLE TO BECOME SICK BEFORE TREATMENT IS AN INHERENTLY EXPENSIVE APPROACH TO HEALTH CARE. A MINIMUM HEALTH INSURANCE STANDARD WOULD COVER ALL HEALTH SERVICES, PROVIDE CARE BEFORE PEOPLE GET TOO SICK, AND SAVE MONEY IN THE PROCESS.

CONCLUSION

S. 1265 WILL BRING ACCESS TO ESSENTIAL HEALTH CARE TO NEARLY ALL OF AMERICA'S WORKING FAMILIES. IN THE PROCESS, THIS BILL WILL PRODUCE SUBSTANTIAL SAVINGS IN ADMINISTRATIVE FEES AND PUBLIC SUBSIDIES AND INTRODUCE SIGNIFICANT ECONOMIES OF SCALE INTO THE HEALTH CARE SYSTEM.

SMALL BUSINESSES WILL BENEFIT FROM FAIRER COMPETITION AND CHEAPER HEALTH INSURANCE PREMIUMS. IN FACT, THEY COULD END UP THE BIGGEST "WINNERS" UNDER THIS BILL.

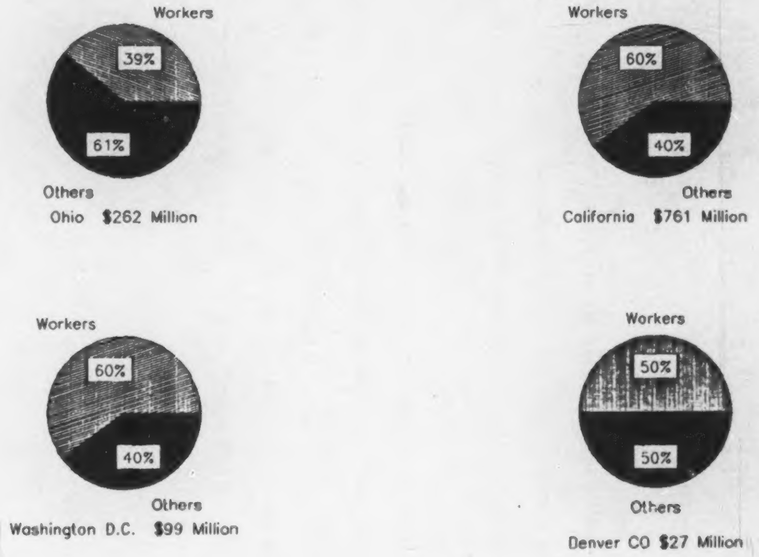
THIS BILL WILL NOT BE A "RADICAL" DEPARTURE FROM THE CURRENT SYSTEM -- IT IS IN THE AMERICAN TRADITION OF SETTING UP MINIMUM LABOR STANDARDS WHICH ALL EMPLOYERS MUST LIVE UP TOO.

IT IS A TRADITION STRONGLY SUPPORTED BY THE AMERICAN PEOPLE. A RECENT SEIU POLL OF REGISTERED VOTERS ON A HOST OF SERVICE SECTOR ISSUES FOUND THAT AMERICANS BY A WHOPPING 4 TO 1 MARGIN SUPPORT A ROLE FOR GOVERNMENT TO SET MINIMUM STANDARDS TO ENSURE THAT JOBS PAY ENOUGH AND HAVE ADEQUATE BENEFITS SO THAT WORKERS CAN TAKE CARE OF THEIR FAMILIES.

MOREOVER, 68% OF THE REGISTERED VOTERS IN OUR POLL FAVOR REQUIRING EMPLOYERS TO OFFER AND PAY FOR AT LEAST 80% OF THE COSTS OF HEALTH INSURANCE -- THE CONTENTS OF THIS LEGISLATION.

THE TIME HAS COME TO PUSH THE PENDULUM BACK TO THE CENTER. WE MUST ESTABLISH A MINIMUM STANDARD FOR BASIC HEALTH CARE AT THE WORKPLACE, AS A COST OF DOING BUSINESS. IN RETURN, THIS BILL WILL REAP ENORMOUS BENEFITS -- DECENT COVERAGE, BETTER HEALTH CARE, PROTECTION AGAINST FINANCIAL HARDSHIP AND PEACE OF MIND FOR TENS OF MILLIONS OF AMERICANS.

UNCOMPENSATED CARE COSTS TO HOSPITALS IN SELECTED CITIES AND STATES



The **Chairman**. Mr. Bieber, you were here during our first panel when we talked about international competitiveness. One of the arguments made against this program is that it is going to decrease our ability to compete internationally. Your testimony is that you believe that if this legislation passed, it could have a positive impact on America's competitive position by removing the costs that are unfairly placed on manufacturing companies. Is that correct?

Mr. **Bieber**. That is correct, Senator. I quite frankly wish that Senator Quayle was here, because I listened to his questioning, and it is ironic, but if you look at Senator Quayle's home State of Indiana, it is a very heavy State for auto parts production—General Motors, Chrysler, as a matter of fact, now they do have one assembly plant in Fort Wayne, but other than that, it is totally parts.

I thought of what has happened in Anderson, Indiana, where you used to have 22,000 workers, and you now have about 6,000, because of the foreign competition; and Kokomo, Indiana; Indianapolis Electric; Chrysler—all plants that have tremendous pressure upon them because of international competition. And Senator, I think of working in Anderson, Indiana when I was director of the General Motors Department, on a horn ring that goes on the horn. And when you are talking about reducing prices by, say, a quarter of a cent to keep those jobs or not, it is not a little item when you look at the costs that are shifted to General Motors.

General Motors pays $2 billion per year in health insurance premiums. That is a lot of money. And because these are good programs, there is a tendency to shift over to those programs.

So that if this bill is passed, it is a relief for those companies who have to face international competition.

The **Chairman**. Do you have any idea what the savings might be in terms of that cost-shifting? I know it is not insignificant, but maybe you can provide that for the record.

Mr. **Bieber**. Let me ask Mr. Hoffman, because they deal with these things.

Mr. **Hoffman**. It is probably in the neighborhood of 4 or 5 percent, but it varies by location of the plant. In many places where we have a large employer in a community, a lot of small employers that circle and supply that employer carve out coverage under their own programs for anyone who is covered under one of our programs, or any of the large employers in the town.

So it varies, but I would suspect that it is substantial. It is at least something that we discuss at every collective bargaining table that we have been at.

The **Chairman**. So you are shoulder-to-shoulder with Chrysler.

Mr. **Bieber**. Yes, Senator. And I think it is worth pointing out that in my Union, we do not just represent Chrysler.

The **Chairman**. That is right.

Mr. **Bieber**. We represent a lot of small companies. We represent companies that are 50 and 35 people and 10 and 15 people, some of 1 and 2. So it is not all one side of the argument.

I recognize the effect upon the small business as well. But I think in your bill—and I compliment you for that—you have taken that into consideration. You have made arrangements where those people can in fact go out and purchase insurance at a much lower cost.

And then I think it comes down basically to this—the right of Americans to have coverage, to be able to have their illness taken care of, is a pretty basic thing. We have to do that, and I think what your bill is doing now is levelling out that floor of responsibility and eliminating some of the tremendous cost shifting that has gone on.

The CHAIRMAN. Excellent.

Mr. Sweeney, your Union represents many low-wage workers. How would you rank affordable health care among their basic needs?

How important is it to them?

Mr. SWEENEY. It is probably their top priority, certainly, next to their wages and job security. As Owen Bieber just said, we view it as a basic right of all Americans.

And just to add a few numbers to Owen's response to your last question, Senator, 70 percent of uninsured workers work for firms in retail trade, services and construction, who do not do any international business nor do they have international competition. A substantial percentage of the uninsured work for employers of 1,000 employees or more. And there are many large employers all across this country who have no insurance for their workers—and I am talking about firms that have 50,000 employees in the service sector.

The CHAIRMAN. We will hear testimony from others today that we can solve the problem by providing the incentives for business to provide health insurance for their workers. Mr. Sweeney, you deal with many of the businesses that do not insure their workers. What do you think? Will they provide insurance voluntarily if we establish some incentives?

Mr. SWEENEY. There will be some, I am sure, who will respond in a positive way to incentives. But as we have said, on minimum standards, we really feel that it is a basic right of all American workers. It is a right that should be covered by mandated protection, and the same standards should apply to all workers and their employers.

The CHAIRMAN. Mr. Bieber, do you have any comment?

Mr. BIEBER. Yes, I agree with that, Senator, and I would only point out that we have experienced some situations now where companies, rather than picking up the responsibility of providing health care benefits for their employees, have opted to gain the favor of the employees by offering certain incentives, which are far less in most cases than what the cost of the insurance would be, which is then an added incentive to shift more of that cost over to other, larger employers.

And I think the route in which your bill is going is the way to go.

The CHAIRMAN. Could you give that to me again?

Mr. BIEBER. Well, we know of situations—we have heard of situations, and I guess we can document that—where employers, rather than providing health care benefits for their employees, pay them a bonus; you know, they give them a little bonus at the end of the year, or quarterly, and therefore shift that cost over to the larger companies—General Motors, Ford, Chrysler.

Senator, I should also say that we have many auto parts companies which are not large in size—1,000 workers, 500 workers, and so on—that have very good health coverage for their workers. And what happens, unless you mandate at least this minimum coverage, everybody tries to shove that burden over on the rest of them. And as someone said earlier, they get hit twice, and they get hit the third time, because people do have to be taken care of. And when these people go into the hospital, we all know that those costs get shifted again, and I think they overburden the shift again to the better-paying plans, which are the bigger companies.

The CHAIRMAN. Well, that is exactly——

Mr. SWEENEY. If I might just add to that—and really, it follows up on the question that Senator Quayle asked the employers earlier, in terms of what made sense, family plan versus single worker plan—sure, on the surface, that sounds like a family plan is the most efficient way. But you have to look at the whole picture, as Owen is referring to, in terms of major employers as well as small businesses that provide coverage. You have to look at how the coordination of benefits work under your bill. The best way to provide the coverage and protect the worker and at the same time provide it at a reasonable cost is with the general provisions of your bill.

The CHAIRMAN. Well, we appreciate that. The fact is there is no such thing as a free lunch in health care. Someone ends up paying for it. What we are trying to do is to rationalize the health care system in ways which are going to be fairer in terms of the community and give some rather basic coverage to people who have not got it and to provide some relief in terms of their mindset, too. You know, we hear a lot about the facts and the figures and the costs, and very little about the anxiety and the concern that families have who are concerned about their children and about their loved ones.

Thank you very much. We appreciate your presence.

Our next panel has two outstanding benefits experts. Philip Briggs is the Vice Chairman of the Board of Metropolitan Life, one of our major health insurers; Carson Beadle is the Managing Director of William M. Mercer-Meidinger-Hansen, Incorporated, one of the largest international benefits consulting firms. He is speaking on behalf of the Association of Private Pension-Welfare Plans, a broad-based organization of those concerned with employee benefits.

Mr. Briggs, we will start off with you.

STATEMENT OF PHILIP BRIGGS, VICE CHAIRMAN OF THE BOARD, METROPOLITAN LIFE INSURANCE AND AFFILIATED CO., NEW YORK, NY, AND CARSON BEADLE, MANAGING DIRECTOR, WILLIAM M. MERCER-MEIDINGER-HANSEN, INC., NEW YORK, NY, AND CHAIR, HEALTH CARE ISSUES COMMITTEE, ON BEHALF OF THE ASSOCIATION OF PRIVATE PENSION-WELFARE PLANS, WASHINGTON, DC

Mr. BRIGGS. Thank you, Mr. Chairman.

My name is Philip Briggs, and I am Vice Chairman of the Board of Metropolitan Life Insurance Company.

Both as a company and a corporate citizen, Metropolitan Life believes that the time has come to attack the problem of the uninsured.

Simply put, the question of how to extend coverage to employees who are now uninsured comes down to a choice between whether benefits will be provided through private insurance or through a public program.

In choosing to build on the present system of private group health insurance instead of a government program, S. 1265 correctly recognizes that the system of employer-provided health coverage has generally served our Nation well.

The private sector insurance industry has provided flexibility, has encouraged innovation and experimentation, and has helped restrain health care costs. As such, we believe that the private insurance approach provides the best opportunity to deliver effective and high-quality health coverage.

For us, the fundamental question raised by this legislation is whether we have arrived at the point where requiring minimum coverage by employers is a necessary step to solve the problem of the uninsured.

We can understand your desire to assure that all employees and their dependents be provided adequate insurance coverage. Nevertheless we still have strong reservations about placing a mandate on employers, especially before carefully considering any alternative program of enhanced incentives.

In the past, we have relied on incentives for achieving certain social objectives. In general, those incentives have done the job, although there have been a few instances where legislative action was taken in order to assure that all citizens had a minimum level of protection. Here, I am thinking of such things as workmen's compensation, minimum wage, Medicare, Social Security, and so on.

We believe that the incentive approach should be reexamined. I think there are some examples of possible new incentives which should be considered. That includes your proposal, sir, to increase the tax credit for self-employed, which as I understand, you have already submitted.

I think there are other credits or incentives which could be introduced for small businesses which might perhaps encourage small employers to provide coverage to their employees.

The CHAIRMAN. You might just submit some of those that you think would be particularly significant.

Mr. BRIGGS. Yes, I will be glad to do that.

The CHAIRMAN. Thank you.

Mr. BRIGGS. We agree that the multitude of State-mandated benefit laws should be preempted. These State laws have inflated the cost of employee benefit plans, have added substantially to the administrative costs, and have forced employers to add benefits which were unneeded by some employees and unwanted by others.

In addition, these laws have interfered with labor and management's judgment as to how to best use the limited funds available for employee benefits.

Providing a basic level of protection and preserving consumer choice of benefits, rather than providing health care providers with income protection, is of prime importance.

We endorse those provisions of S. 1265 that encourage the use of managed care systems as a key feature in controlling overall health insurance costs.

We believe the private sector has done an excellent job of applying cost containment measures to control costs, and we are very pleased that the bill provides encouragement for those kinds of activities.

One of the criticisms of the private sector insurance market which appears to have influenced the structure of this bill is the belief that small group coverage while available, tends to be unaffordable for many small businesses. As we understand it, this is part of the rationale for creating the structure of regional insurers called for by the legislation.

The theory is that such regions will benefit the small employer by producing economies of scale and aggregating purchasing power for health insurers serving such employers.

Our preference, however, is that any legislation maximize the use of the existing market system. We are not quite sure this bill does that as it is presently drafted. We think there are alternatives which should be considered which would do so.

We have also examined the minimum benefits proposed in the bill, and we believe that closer analysis is required. We believe the proposed benefit package may be too rich and would not offer a true minimum, which is the purpose of the bill.

Secondly, the minimum value of the plan will set a standard for all employers who now provide health care coverage. By including the concept of actuarial equivalents, you have attempted to provide a means of avoiding unnecessary disturbance of existing plan structures, and this, we applaud.

In our view, it is essential that this concept be carefully and clearly defined in any emerging legislation.

We are concerned that the new area of Federal jurisdiction which will result from the enactment of this bill could easily lead to replication of what has occurred at the State level, namely, mandated benefits. There is a big difference, in our minds, between establishing a minimum level of coverage and mandating a long list of specific benefits.

Your proposal if enacted would have very significant impact on my company and our customers. While we share your goal and want to see a solution to the problem of the uninsured, we also believe that with an issue of this magnitude, we all have an obligation to be very careful and deliberate in seeking the correct solution.

It should also be recognized that the lack of employer-related coverage is only a part of the problem. To a large extent, there is a correlation between lack of coverage and low income. About three-quarters of all uninsured workers earn less than $10,000 a year. It is important that Medicaid's role in providing health coverage for these individuals be strengthened to do the job it was originally intended to do, which is to provide health care to the poor.

Thank you very much, Mr. Chairman.

The **Chairman**. Thank you very much.

[The prepared statement of Mr. Briggs follows:]

TESTIMONY OF

PHILIP BRIGGS
VICE-CHAIRMAN OF THE BOARD

METROPOLITAN LIFE INSURANCE AND
AFFILIATED COMPANIES

NEW YORK, NEW YORK

before the

SENATE LABOR COMMITTEE ON LABOR
AND HUMAN RESOURCES

on

S. 1265, THE MIMIMUM HEALTH BENEFITS FOR
All WORKERS ACT OF 1987

JUNE 24, 1987

MR. CHAIRMAN

MY NAME IS PHILIP BRIGGS, AND I AM VICE-CHAIRMAN OF THE BOARD OF METROPOLITAN LIFE INSURANCE COMPANY.

THANK YOU FOR GIVING US AN OPPORTUNITY TO COMMENT ON YOUR BILL TO PROVIDE A MINIMUM LEVEL OF HEALTH COVERAGE TO ALL WORKERS.

METROPOLITAN HAS BEEN AN INSURER AND AN ADMINISTRATOR OF EMPLOYEE BENEFIT PLANS FOR MANY YEARS. CURRENTLY, WE INSURE OR ADMINISTER PLANS COVERING 7.7 MILLION EMPLOYEES AND THEIR DEPENDENTS. CONSEQUENTLY, WE RECOGNIZE HOW DIFFICULT AND COMPLEX A PROBLEM IT IS TO EXTEND COVERAGE TO THE ENTIRE RANGE OF ENTERPRISES IN THIS COUNTRY, AND TO BALANCE THE SOCIAL OBJECTIVES OF EXTENDING COVERAGE TO MILLIONS OF UNINSURED AMERICANS AGAINST THE ECONOMIC IMPACT THAT MANDATED HEALTH INSURANCE COVERAGE WOULD HAVE ON A VAST NUMBER OF EMPLOYERS IN THE COUNTRY, PARTICULARLY SMALLER ONES.

RAPIDLY RISING HEALTH CARE COSTS AND DRAMATIC INCREASES IN THE NUMBER OF UNINSURED CLEARLY HAVE THE ATTENTION OF CONGRESS. ALTHOUGH 181 MILLION AMERICANS ARE COVERED BY PRIVATE INSURANCE, THERE ARE MANY MILLIONS MORE WHO LACK HEALTH INSURANCE PROTECTION TODAY. SOME ESTIMATES PLACE THIS NUMBER AS HIGH AS 35 MILLION INDIVIDUALS, ALTHOUGH A RECENT STUDY PUBLISHED BY THE ROBERT WOOD JOHNSON FOUNDATION PLACES THE NUMBER CLOSER TO 22 MILLION. SINCE THE QUESTION OF THE NUMBER OF UNINSURED IS OF VITAL PUBLIC POLICY IMPORTANCE, IT IS ESSENTIAL THAT AN ACCURATE ESTIMATE OF THE NUMBER OF UNINSURED BE DEVELOPED.

MOST UNCOVERED INDIVIDUALS HAVE AN EMPLOYMENT CONNECTION. VARIOUS STUDIES HAVE SHOWN THAT MOST UNCOVERED EMPLOYEES WORK FOR SMALL BUSINESS CONCERNS. ALSO UNPROTECTED ARE INDIVIDUALS

WHO, DESPITE THEIR LOW INCOME, DO NOT QUALIFY FOR MEDICAID OR INDIVIDUALS WHO HAVE SUBSTANTIAL INCOME BUT ARE UNINSURABLE.

THIS LACK OF INSURANCE MAKES IT DIFFICULT TO OBTAIN ACCESS TO OUR MEDICAL CARE SYSTEM. WHEN THE UNINSURED DO GAIN ACCESS, THE BURDEN OF THEIR UNCOMPENSATED CARE IS SPREAD UNFAIRLY OVER THOSE EMPLOYERS WHO DO PROVIDE COVERAGE TO THEIR EMPLOYEES.

PRIVATE SECTOR SOLUTION

BOTH AS A COMPANY AND AS A CORPORATE CITIZEN, METROPOLITAN LIFE BELIEVES THAT THE TIME HAS COME TO ATTACK THE PROBLEM OF THE UNINSURED.

IMPLICIT IN S. 1265, HOWEVER, IS THE JUDGEMENT THAT THE IMPORTANCE OF EXTENDING COVERAGE TO THE EMPLOYED UNINSURED IS MORE IMPORTANT TO THE COUNTRY THAN ANY ADVERSE ECONOMIC IMPACT ON SMALL BUSINESS AND ANY POTENTIAL LOSS OF JOBS OR TAX REVENUES SUCH DISLOCATIONS MIGHT PRODUCE. IN THIS CONNECTION, IT IS IMPORTANT TO NOTE THAT SMALL EMPLOYERS ARE THE ONES WHICH ARE CREATING MOST OF THE NEW JOB OPPORTUNITIES IN THE COUNTRY.

IN ANY EVENT, IF THE CONGRESS ULTIMATELY ADOPTS A MANDATE APPROACH WE ARE CONCERNED WITH HOW COVERAGE WILL BE DELIVERED.

SIMPLY PUT, THE QUESTION OF HOW TO EXTEND COVERAGE TO EMPLOYEES WHO ARE NOW UNINSURED COMES DOWN TO A CHOICE BETWEEN WHETHER BENEFITS WILL BE PROVIDED THROUGH PRIVATE INSURANCE OR THROUGH A PUBLIC PROGRAM. IN CHOOSING TO BUILD ON THE PRESENT SYSTEM OF PRIVATE GROUP HEALTH INSURANCE, INSTEAD OF A GOVERNMENT PROGRAM, S. 1265 CORRECTLY RECOGNIZES THAT THE SYSTEM OF EMPLOYER PROVIDED HEALTH COVERAGE HAS GENERALLY SERVED OUR NATION WELL AND IS THE BEST WAY TO APPROACH THE PROBLEM OF THE EMPLOYED UNINSURED.

METROPOLITAN IS PROUD OF ITS RECORD OF PROVIDING QUALITY MEDICAL CARE FOR A SIGNIFICANT PART OF OUR POPULATION IN AN EFFICIENT, COST-EFFECTIVE MANNER. THE PRIVATE SECTOR INSURANCE INDUSTRY HAS PROVIDED FOR FLEXIBILITY, HAS ENCOURAGED INNOVATION AND EXPERIMENTATION, AND HAS HELPED RESTRAIN HEALTH CARE COST ESCALATION. AS SUCH, WE BELIEVE THAT THE PRIVATE INSURANCE APPROACH PROVIDES THE BEST OPPORTUNITY TO DELIVER EFFECTIVE AND QUALITY HEALTH COVERAGE.

THE MANDATE ISSUE

FOR US, THE FUNDAMENTAL QUESTION RAISED BY THIS LEGISLATION IS WHETHER WE HAVE ARRIVED AT THE POINT WHERE REQUIRING MINIMUM COVERAGE BY EMPLOYERS IS A NECESSARY STEP TO SOLVE THE PROBLEM OF THE UNINSURED.

WE CAN UNDERSTAND YOUR DESIRE TO ASSURE THAT ALL EMPLOYEES AND THEIR DEPENDENTS BE PROVIDED ADEQUATE INSURANCE COVERAGE. FROM AN INSURANCE POINT OF VIEW, MANDATORY COVERAGE WOULD GO A LONG WAY TOWARD ELIMINATING THE ADVERSE SELECTION WHICH CURRENTLY EXISTS IN THE SMALL GROUP MARKET.

NEVERTHELESS, WE HAVE STRONG RESERVATIONS ABOUT PLACING A MANDATE ON EMPLOYERS, ESPECIALLY BEFORE CAREFULLY CONSIDERING A PROGRAM OF ENHANCED INCENTIVES.

ENHANCED INCENTIVES

IN THE PAST, WE HAVE RELIED ON INCENTIVES FOR ACHIEVING CERTAIN SOCIAL OBJECTIVES. IN GENERAL, THOSE INCENTIVES HAVE DONE THE JOB ALTHOUGH THERE HAVE BEEN A FEW INSTANCES WHERE LEGISLATIVE ACTION WAS TAKEN IN ORDER TO ASSURE THAT ALL CITIZENS HAD A MINIMUM LEVEL OF PROTECTION.

WE BELIEVE THAT THE INCENTIVE APPROACH SHOULD BE RE-EXAMINED. SOME EXAMPLES OF POSSIBLE NEW INCENTIVES WHICH SHOULD BE CONSIDERED WOULD INCLUDE EXTENDING FULL DEDUCTIBILITY OF HEALTH INSURANCE PREMIUMS TO THE SELF-EMPLOYED, PROVIDING LOW-INCOME EMPLOYEES WITH LIMITED TAX CREDITS FOR ANY CONTRIBUTIONS THEY MAKE AS PART OF AN EMPLOYER SPONSORED PLAN, AND PROVIDING ADDITIONAL TAX INCENTIVES TO EMPLOYERS WITH RELATIVELY LOW EARNINGS IN ORDER TO HELP THEM PROVIDE HEALTH CARE COVERAGE FOR THEIR EMPLOYEES.

PREEMPTION OF MANDATED BENEFITS

WE AGREE THAT THE MULTITUDE OF STATE MANDATED BENEFIT LAWS SHOULD BE PREEMPTED. THESE STATE LAWS HAVE INFLATED THE COST OF EMPLOYEE BENEFIT PLANS, HAVE ADDED SUBSTANTIALLY TO ADMINISTRATIVE COSTS AND HAVE FORCED EMPLOYERS TO ADD BENEFITS WHICH WERE UNNEEDED BY SOME EMPLOYEES AND UNWANTED BY OTHERS. IN ADDITION, THESE LAWS HAVE INTERFERED WITH LABOR AND MANAGEMENT'S JUDGEMENT AS TO HOW BEST TO USE THE LIMITED FUNDS AVAILABLE FOR EMPLOYEE BENEFITS. PROVIDING A BASIC LEVEL OF PROTECTION AND PRESERVING CONSUMER CHOICE OF BENEFITS RATHER THAN PROVIDING HEALTH CARE PROVIDERS WITH INCOME PROTECTION IS OF PRIME IMPORTANCE. UNFORTUNATELY, TOO OFTEN IN THE PAST STATE MANDATED BENEFIT LAWS HAVE BEEN DRIVEN BY THE LATTER OBJECTIVE RATHER THAN THE FORMER.

PRIVATE SECTOR COST CONTAINMENT

WE ENDORSE THOSE PROVISIONS OF S. 1265 THAT ENCOURAGE THE USE OF MANAGED CARE SYSTEMS AS A KEY FEATURE IN CONTROLLING OVERALL HEALTH INSURANCE COSTS.

WE BELIEVE THE PRIVATE SECTOR HAS DONE AN EXCELLENT JOB OF APPLYING COST CONTAINMENT MEASURES SUCH AS REQUIRED SECOND SURGICAL OPINIONS FOR SELECTED PROCEDURES, INDIVIDUAL CASE

MANAGEMENT, PRECERTIFICATION FOR HOSPITAL ADMISSIONS, AND SELECTIVE CONTRACTING BASED ON CLOSE ANALYSIS OF COST AND UTILIZATION DATA. IT IS THROUGH THESE COST CONTAINMENT MEASURES AND MANAGED CARE SYSTEMS (E.G., HMOS AND PPOS) THAT WE ARE INCREASINGLY ASSISTING OUR CUSTOMERS TO BRING BETTER QUALITY HEALTH CARE SERVICES TO THEIR EMPLOYEES IN THE MOST EFFICIENT WAY POSSIBLE.

AS WE READ THE BILL IT IS EVIDENT THAT YOU RECOGNIZE THE CRUCIAL ROLE THESE PRIVATE SECTOR EFFORTS CAN MAKE IN SOLVING THE PROBLEM OF THE UNINSURED.

REGIONAL INSURANCE PLANS

ONE OF THE CRITICISMS OF THE PRIVATE SECTOR INSURANCE MARKET WHICH APPEARS TO HAVE INFLUENCED THE STRUCTURE OF THIS BILL IS THE BELIEF THAT SMALL GROUP COVERAGE, WHILE AVAILABLE, TENDS TO BE UNAFFORDABLE FOR MANY SMALL BUSINESSES. AS WE UNDERSTAND IT, THIS IS PART OF THE RATIONALE FOR CREATING THE STRUCTURE OF REGIONAL INSURERS CALLED FOR BY THE LEGISLATION.

THE THEORY IS THAT SUCH REGIONS WILL BENEFIT THE SMALL EMPLOYER BY PRODUCING ECONOMIES OF SCALE AND AGGREGATE PURCHASING POWER FOR HEALTH INSURERS SERVING SUCH EMPLOYERS. IT IS AN INTERESTING CONCEPT WHICH WE ARE CAREFULLY STUDYING. OUR PREFERENCE, HOWEVER, IS THAT ANY LEGISLATION MAXIMIZE THE USE OF THE EXISTING MARKET SYSTEM.

MINIMUM HEALTH BENEFITS

WE HAVE ALSO EXAMINED THE MINIMUM BENEFITS PROPOSED IN THE BILL AND BELIEVE CLOSER ANALYSIS IS REQUIRED.

THE MINIMUM BENEFIT PACKAGE HAS TWO VERY SIGNIFICANT AND RELATED ROLES IN THE STRUCTURE OF THE BILL. SINCE UNDER YOUR PROPOSAL

EMPLOYERS WHO DO NOT NOW PROVIDE COVERAGE WOULD BE REQUIRED TO DO SO, THE COST OF THE PACKAGE WILL DIRECTLY AFFECT THE BOTTOM LINE OF EVERY ONE OF THOSE BUSINESSES.

WE BELIEVE THE PROPOSED BENEFIT PACKAGE IS TOO RICH AND WOULD NOT OFFER A TRUE MINIMUM, WHICH IS THE PURPOSE OF THE BILL.

SECONDLY, THE MINIMUM VALUE OF THE PLAN WILL SET A STANDARD FOR ALL EMPLOYERS WHO NOW PROVIDE HEALTH CARE COVERAGE. BY INCLUDING THE CONCEPT OF ACTUARIAL EQUIVALENCE, YOU HAVE ATTEMPTED TO PROVIDE A MEANS OF AVOIDING UNNECESSARY DISTURBANCE OF EXISTING PLAN STRUCTURES. IN OUR VIEW, IT IS ESSENTIAL THAT THIS CONCEPT BE CAREFULLY AND CLEARLY DEFINED IN ANY EMERGING LEGISLATION AND NOT TURNED OVER TO A REGULATORY AGENCY FOR DEVELOPMENT.

WE ARE ALSO CONCERNED THAT THE NEW AREA OF FEDERAL JURISDICTION WHICH WILL RESULT FROM THE ENACTMENT OF THIS BILL COULD EASILY LEAD TO REPLICATION OF WHAT HAS OCCURRED AT THE STATE LEVEL. THERE IS A BIG DIFFERENCE, IN OUR MIND, BETWEEN ESTABLISHING A MINIMUM LEVEL OF COVERAGE AND MANDATING A LONG LIST OF SPECIFIC BENEFITS. WE RECOGNIZE THAT S. 1265 SEEKS TO ADDRESS OUR CONCERN IN THIS AREA. HOWEVER, THE PROCEDURAL PROTECTIONS RELATING TO THE ADDITION OF NEW BENEFITS CONTAINED IN THE PROPOSAL SHOULD BE SIGNIFICANTLY STRENGTHENED TO SATISFY WHAT WE REGARD AS LEGITIMATE CONCERNS.

CONCLUSION

THE ISSUE OF PROVIDING ADEQUATE HEALTH INSURANCE FOR ALL AMERICANS HAS BEEN A NATIONAL CONCERN FOR OVER FIFTY YEARS. IT HAS ALWAYS BEEN A COMPLEX PROBLEM, AND IT IS NO LESS SO TODAY. THE CENTRAL FEATURES OF S. 1265 DEAL WITH THE PRIVATE INSURANCE MARKET. YOUR PROPOSAL, IF ENACTED, WOULD HAVE A VERY SIGNIFICANT IMPACT ON MY COMPANY AND OUR CUSTOMERS. WHILE WE

SHARE YOUR GOAL AND WANT TO SEE A SOLUTION TO THE PROBLEM OF THE UNINSURED, WE ALSO BELIEVE THAT WITH AN ISSUE OF THIS MAGNITUDE WE ALL HAVE AN OBLIGATION TO BE VERY CAREFUL AND DELIBERATE IN SEEKING THE CORRECT SOLUTION.

IT SHOULD BE RECOGNIZED THAT THE LACK OF EMPLOYER RELATED COVERAGE IS ONLY PART OF THE PROBLEM. TO A LARGE EXTENT THERE IS A CORRELATION BETWEEN LACK OF COVERAGE AND LOW INCOME. ABOUT 3/4 OF ALL UNINSURED WORKERS EARN LESS THAN $10,000 A YEAR, AND ONE OUT OF EVERY THREE UNINSURED PERSONS LIVES IN A FAMILY WHICH HAS AN INCOME BELOW THE POVERTY LEVEL. IT IS IMPORTANT THAT MEDICAID'S ROLE IN PROVIDING HEALTH COVERAGE FOR THESE INDIVIDUALS BE STRENGTHENED TO DO THE JOB IT WAS ORIGINALLY INTENDED TO DO -- PROVIDE HEALTH CARE TO THE POOR.

I THANK YOU AND THE COMMITTEE FOR GIVING ME THE OPPORTUNITY TO APPEAR HERE TODAY.

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The **Chairman**. Mr. Beadle.

Mr. **Beadle**. Mr. Chairman, Members of the Committee, I am Carson Beadle, of Mercer-Meidinger-Hansen. I am here today representing the Association of Private Pension and Welfare Plans, the APPWP, whose Health Issues Committee I chair, and on whose Executive Committee I serve.

The APPWP's primary goal is protecting and fostering the growth of America's private employee benefit system. Although in today's proceedings we are listed under insurers, our members represent over 200 employers of all sizes in addition to organizations that support benefit plans, such as banks, insurance companies, and benefit firms.

After study and review within that diverse group, I am representing today a broad consensus and not a unanimous view. I would like to personally commend you and your staff for your outstanding efforts to involve many interest groups and experts in this innovative program. We at the APPWP share your interest in expanding health care coverage to all Americans. We have given considerable thought to achieving this worthy objective without impairing the private sector system that, through its own voluntary means, already covers a remarkable 85 percent of America's workers and their families, more than 132 million people.

The Employee Benefit Research Institute estimates that S. 1265 will cover about 23 million of the 35 million uninsured, or about 15 percent of the worker population.

Our objective in assessing S. 1265 has been that in covering the uninsured population, we should not impair the system that now protects the other 85 percent of our work force.

In analyzing the final bill, we were confronted with some serious dilemmas. First, we oppose virtually all mandated programs that limit a firm's ability to adjust its compensation package, its hiring practices and its expenses, thereby preventing it from performing competitively. With our current position in world markets and the growing importance of small business in our domestic markets, the need for flexibility is clear.

Second, we agree with you that all Americans should have access to basic health care, and we find S. 1265 superior to other proposals in Congress, and we believe its objectives warrant our most thoughtful consideration. We thought it would be useful to tell you some of the provisions we think will work and some we believe will not support a workable basic plan.

The preemption of State-mandated plans that you have proposed is extremely important. Without this preemption and the difficulties in living with both Federal and State mandates, our membership would have resisted the proposed plan.

We endorse the flexibility in Section 311 that permits employers to vary their health insurance package to most effectively meet the needs of their work force. The provision to limit expenses to those which are medically necessary is essential. More definitive language is needed to ensure that the drafters of regulations understand that it is your intention that employers be encouraged to control the worrisome increases in health care costs.

We believe the annual deductible of $250 for single-employee coverage and $500 for family coverage should be indexed.

Given the continuing climb in health care costs, we applaud the flexibility in health cost containment that is permitted under the bill by allocating higher copayments to be charged to those who refuse to avail themselves of the savings of managed care.

There are many fundamental provisions of this program, then, that are well-received. There are other points with which we have had considerable difficulty.

A waiting period of as little as 30 days for new employees creates an intolerable burden for employers with high turnover in the first few weeks, both administratively and in the COBRA extension they would be required to provide. We strongly recommend flexibility to permit a six-month waiting period.

Defining full-time employees as those working 17½ hours per week will require important changes in practices for many of our members. A 20-hour minimum would answer most of these problems.

Growing flextime and part-time employment are increasingly meeting the needs of employees and their families. However, for the employer who accommodates these people by hiring two to cover a week's work in place of one, the employer is confronted with a double health care cost. We ask you to consider permitting employers to pro-rate their contribution for part-time employees.

Many employers pay most or all of the costs of present plans for employees, but do not contribute for dependents. That trend has arisen in part out of the equal pay movement. For many employers to now suddenly have to pay 80 percent of the full dependent cost would be quite onerous. We would encourage a phase-in period to reach 80 percent payment for dependents.

Special provision is made in the bill for first-dollar coverage for prenatal and well-baby care. We understand your objectives in including this provision. However, there are many important services and procedures which vary in their importance, depending on the age of the group, occupational hazards, and a host of issues which the group itself is much better able to determine than the Federal government. We disagree with having any benefits specifically described in the bill or in regulation.

We agree with you, Mr. Chairman, that it will be only a matter of time before various specialties will lobby their interests, and the flexibility you have given employers to meet their special needs will be lost. Our membership would strongly resist any bill that specifies mandatory procedures or services.

While small employers are not the group we essentially represent, we wish to express our serious concern that the additional costs and administration of the plan, plus those of any other legislation such as minimum wage, can have a stultifying effect on this vibrant sector of our economy.

In closing, Mr. Chairman, I would again congratulate you on your outstanding initiative in seeking out the concerns of industry and in starting a focused national debate. We hope our observations will be seen as constructive and useful.

[The prepared statement of Mr. Beadle follows:]

TESTIMONY OF

ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

ON

"MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987"

[S. 1265]

BEFORE

COMMITTEE ON LABOR AND HUMAN RESOURCES, UNITED STATES SENATE

JUNE 24, 1987

CARSON E. BEADLE
MANAGING DIRECTOR, WM. M. MERCER-MEIDINGER-HANSEN, INC.
CHAIR, APPWP HEALTH CARE ISSUES COMMITTEE
[Witness]

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Mr. Chairman and Members of the Committee, I am Carson E. Beadle, Managing Director of William M. Mercer-Meidinger-Hansen. I represent the Association of Private Pension and Welfare Plans (APPWP), whose Health Care Issues Committee I chair and on whose Executive Committee I serve. The APPWP is a nonprofit organization founded in 1967 with the primary goal of protecting and fostering the growth of America's private employee benefit system. The APPWP's members represent large and small employers as well as the leading support organizations to benefit plans: investment firms, banks, insurance companies, accounting, benefits consulting and actuarial firms. This is a diverse group. After considerable study and review of S. 1265, the comments I offer represent a broad consensus but not a unanimous view.

We appreciate this opportunity to testify. We commend you and your staff for your outstanding efforts to involve many interest groups and experts in the design and modification of your proposed plan and for your willingness to modify various provisions of the bill to ameliorate concerns identified earlier. We believe your proposal commences what should become a comprehensive public debate on health care coverage, cost and ethical issues.

The APPWP shares your interest in expanding health care coverage to all Americans. We have devoted considerable study to how best to achieve this worthy objective without impairing the private sector system that, through its own voluntary means, already covers a remarkable 132 million Americans according to Employee Benefit Research Institute estimates.

GENERAL COMMENTS

The APPWP is opposed to the growth in government-mandated programs in the private workplace. It is a common truism that domestic and international markets are changing rapidly. Flexibility is central to the ability of American employers to compete in today's world. By definition mandated programs reduce flexibility and have always been strongly resisted by our members. They therefore should be subject to careful scrutiny before their adoption. To expand the availability of the private sector benefits system, we would suggest that Congress further consider appropriate tax and other incentives for voluntary rather than mandatory coverage. In this regard, we support full deductibility of health coverage costs for the self-employed who in turn cover their own employees. Other voluntary alternatives must be more fully explored.

The APPWP historically has opposed mandates on employers as a way to broaden employee benefit coverages. While we continue to believe that the approach envisioned in S. 1265 has some serious problems, it is less objectionable than other mandated benefit proposals considered in the past or being advanced elsewhere in the 100th Congress. For example, some have suggested state subsidized pools as the means of extending coverage to all uninsured persons. We seriously question the efficacy of this solution.

Our membership strongly supports preemption of state mandated benefits for all employer-sponsored health benefit plans. We applaud this provision of your proposal and believe that the cost reductions for small employers which will result could be significant. In fact, Federal preemption of State mandated benefits is in our view an essential condition of the bill.

We urge the committee to consider carefully the effect of this bill on small businesses that employ minimum wage workers and are heavily labor intensive. Three quarters of the uninsured earn less than $10,000 a year; for these employers the combination of this bill and the pending minimum wage bill could well mean the inability to stay in business. Many argue that these bills will increase unemployment and drive more workers into the underground economy.

In addition, there are provisions in the bill that need clarification or change. One change that is critical concerns mandating coverage, rather than specific benefits.

MANDATED COVERAGE V. MANDATED BENEFITS

We want to draw a sharp distinction between federally mandated coverage within broad actuarially valued limits and federally mandated specific benefits. Only the coverage mandate merits any consideration at all. It is a matter of serious concern that this proposal should in no way become a vehicle for imposing standaridized benefit programs.

We endorse the flexibility in section 311 of the bill that would permit employers to vary their health insurance package in a way that most effectively and appropriately meets the needs of their workforce. We are flatly and firmly opposed to any federal bill that mandates specific benefits which all plans must provide, rather than mandating a minimum level of coverage and allowing the employer to determine how the costs of that coverage should be allocated to any particular benefit. The bill should also specifically allow a flexible benefits or cafeteria plan approach

We do not support the mandate of any specific benefits at any specific levels. Therefore we strongly oppose the bill's restriction on pre-existing coverage exclusions, and the specific inclusion of well baby care and prenatal care without co-payments or deductibles, pursuant to a schedule of benefits in these two areas that is federally mandated through regulation by the Secretary of Health and Human Services. We do not disagree that these benefits are valuable; however, many other specific benefits are also of great value and the attractive feature of your bill is that an employer would be free to develop their own base plan. Having any benefits specified contradicts this feature.

The federal government is not in the best position to tell all employers what specific benefits their employees need most. It is not the worth of any particular benefit that we debate; rather, we reject the intrusion of the federal government in the process of establishing benefits.

What is at issue here is not the number of benefits required. Specifying and mandating these few benefits is just the start down a road we find dangerous and objectionable. If we have learned anything from the experience of benefits mandated by states it is that the list grows. Dictating specific benefits is costly; it leads to poor utilization of health care and it interferes with effective cost containment. In addition, the elaborate mechanism in the bill for adding additional mandated benefits will not serve as a deterrent.

OTHER CONCERNS

There are a variety of other areas which, in our view, require some rethinking.

Eligibility Standards

The eligibility standards in the bill are too stringent and do not reflect a realistic assessment of a worker's attachment to an employer sufficient to justify the cost of coverage. A waiting period of as little as 30 days for new employees creates an intolerable burden for employers with high turnover in the first few weeks of employment both administratively and the COBRA extension they would be required to provide. We strongly recommend flexibility to permit a six month waiting period. Only employees entering permanent employment for the first time would be affected. Those coming from another job would have had the opportunity to take extended COBRA coverage from their prior employer. We would also suggest a standard of 1000 hours per year, or 20 hours per week. The 1000 hour standard is not without precedent; it is the standard used for qualified retirement plans under ERISA. Most employers already use this standard in determining eligibility. The use of 17-1/2 hours will surely result in employers reducing the hours of its part time employees; this can hardly be the result you seek. Instead, the bill should permit some prorating of either coverage or employer cost for employees who work between 20 hours and "full time." This approach would prevent burdensome health coverage costs from being a disincentive to hiring part-time employees.

Coverage and Savings

We are also concerned that the bill not interfere with the normal prerogatives of health plan administrators in determining what care is "medically necessary," and what is "experimental." Procedures such as elective cosmetic surgery, radial keratotomies, and weight reduction for example can hardly be considered "medically necessary." More definitive language is needed to ensure that the drafters of regulations will understand that it is the intention of the bill that eligible expenses may be controlled. The bill should contain an explicit clause that retains for the plan administrator all authority and discretion in this area.

The drafters of our current Medicare program realized that the determination of medically necessary care cannot be legislated but requires a facts and circumstances review of each case. Indeed, the Health Care Financing Administration has been given a broad mandate to establish general guidelines for that determination and the Medicare administrators and fiscal intermediaries have the discretion to make specific case decisions. We urge a similar approach be used in mandating health care coverage in this bill.

Health care costs have been rising at an alarming rate and continue to do so. It is for this reason we strongly support the provision which allows a plan to alter co-payments if an employee fails to use the plan's cost-containment features; however, we believe this clause does not give the plan sponsor sufficiently clear authority. We would, instead, add a floor below which cost sharing could not be required. Our proposal would be 50 percent cost sharing for failure to use the plan's rules with the intermediate steps being governed by the employers and insurers views of effective cost control.

Apportioning

S. 1265 does not permit an employee to waive his or her individual coverage. It is vague, however, on how the dependents ought to be "apportioned" in the case of two working parents. We have had success with what has come to be known as the "birthday rule," and we would suggest that where there is dual coverage, its use be required.

Small Employers

We think the bill needs to clarify the treatment of small employers who are already providing coverage through multiemployer plans, METs, associations, or group plans for franchises. We believe it would be a mistake for the bill to upset these arrangements and throw participating employers into a regional delivery system.

Repeal of IRC Sec. 89

There are other concerns that must also be addressed. We strongly recommend that S. 1265 repeal the complex and unadministrable coverage rules for health plans enacted by Congress in 1986 as part of tax reform. The rules, in section 89 of the Internal Revenue Code, were intended to broaden employer sponsored coverage and prevent discrimination in the provision of health insurance. S. 1265 will substantially reduce the potential for discrimination; because all employees will now be covered, complex percentage tests to determine whether an adequate number of employees are covered will become largely superfluous and a waste of money spent in administrative costs. While an employer may still provide differing levels of insurance to its employees, the span of coverage is not large enough to justify the enormous regulatory burden of section 89. Once S. 1265 has had an opportunity to work, Congress can then more usefully assess whether and to what extent additional tax code based discrimination rules are necessary.

Cost Containment

We urge you to consider cost containment initiatives that include not only plans, plan sponsors, and employees in their scope but providers as well. Plan design can go only so far in bringing down the improper or unnecessary utilization of health care. In many ways, however, current cost containment measures put the burden of saying "no" or asking "why" on the patient -- the individual with the immediate health problem. Moreover, to the extent any plan refuses to pay charges that exceed the reasonable and customary level -- a plan provision we believe essential to successful cost containment -- it is the patient who bears the additional costs and who can least effectively negotiate with the provider. What we have all learned about health care cost inflation in the last several years is that cost containment is very difficult and susceptible of no easy solutions. We don't claim to have a major solution but we know that without an effort that includes employers, insurers and providers, cost containment won't be fully successful.

Self-employed

Finally, although the Chairman's introductory remarks promised a companion bill that would allow the self-employed a tax deduction of 80 percent of health care costs, we think such a provision must be part of this bill and the costs must be fully deductible, assuming that health insurance is, in fact purchased, for the self-employed and his/her workers. There is no reason why the self-employed should continue to be disadvantaged with respect to the tax incentives for health insurance. If health insurance coverage is important enough to mandate it on virtually all employers, it is absurd to suggest that business form should dictate whether the tax laws will make that mandate less expensive. Over 25 percent of the uninsured workers are self-employed -- nearly five million individuals fall into this category. Their health coverage must be fully deductible if the goal of S. 1265 -- nearly universal worker coverage -- is to be achieved.

Regional Delivery Systems

The proposed regional delivery systems for small employers which is intended to reduce health insurance costs is troublesome. Numerous questions about the regional arrangement have been raised, including the appropriate number of regions, the size of employers to be included, whether small employers should be required to participate in the system, the nature and variety of insurance offered, and the very basic issue of restricting the marketplace. We have not as yet been able to come up with any easy answers to these and similar questions, although they have been carefully and thoughtfully considered on numerous occasions by our membership. Our Health Care Issues Committee will continue to address these questions and search for possible alternative solutions.

CONCLUSION

I have touched on a number of points and commented on several aspects of your proposal in this statement. Let me pull together the unifying threads.

Our members share your belief that expanding health care coverage to all Americans is desirable and important. We note that the existing voluntary private sector system currently covers 56 percent of all American workers and their families. A quarter of those not covered are self-employed; we urge you to offer them relief and assistance in the same bill you expand coverage of all employees.

We are concerned about the growth in federally mandated programs. We believe the presumption, in an argument, should be against a federal mandate. We recognize however, that efforts have been made to make federal mandating of health coverage acceptable by limiting the mandate to coverage in general and to preempting existing state laws. We cannot agree to a list of specific benefits. The particular package of benefits must be left to the employer and employee. We believe the federal government is ill-equipped to dictate to individual businesses and workers how their health care dollars shall be spent. All of our members strongly prefer that Congress focus its efforts and invest national financial resources on alternatives that encourage and support the expansion of the voluntary system to fill coverage gaps that presently exist in our society.

We have great concern that as this bill winds its way through Congress, its terms and conditions will be broadened and its essential limitations weakened. We are further concerned about the details that will be embedded in the definitions and the regulations promulgated after enactment. We have offered some suggestions in these important areas and will continue to be available to work with your staff who have done an outstanding job of constructive discussion.

The private benefits system has served this nation and its workforce well. We look forward to working with you in further expanding access to health coverage.

The **Chairman**. Our distinguished Senator from Connecticut, who is our prime cosponsor, will be chairing the hearing in this period.

I have just a few questions.

Senator **Weicker** [presiding]. Fine.

The **Chairman**. Mr. Briggs, is it true that uninsured individuals are in some instances receiving hospital care today? And if that is true, how is the cost of that care being allocated?

Mr. **Briggs**. Well, it is true, Senator, that people who have no insurance do receive care when they are in dire straits. I think people who cannot demonstrate urgent need are probably not getting the care they should get. But the ones that do get the care, their cost is being spread out over the people who are able to pay, and that is primarily the insured population.

So that indirectly what is happening is that employers who have plans are paying for the people who are now uninsured.

The **Chairman**. Can the hospitals allocate that cost to the government programs today?

Mr. **Briggs**. They do not, sir. Medicare and the Medicaid programs do not pick up any part of that uncompensated care, and so the entire burden is on the private sector, currently.

The **Chairman**. So the employers are now bearing the full brunt of the uncompensated care.

Mr. **Briggs**. That is correct, Senator.

The **Chairman**. Do you have any estimate of what that is costing?

Mr. **Briggs**. I do not have an exact number, Senator, but I am told that the cost shift which occurs from Medicare has been estimated in the magnitude of about $6 billion a year.

The **Chairman**. From Medicare?

Mr. **Briggs**. Yes—from Medicare alone.

The **Chairman**. And what about for those outside of Medicare—are there any figures?

Mr. **Briggs**. I do not know, Senator, I do not know.

The **Chairman**. We would appreciate any information that you can provide—that would be $6 billion that you can identify that now is being picked up by companies that provide health insurance.

Mr. **Briggs**. I think we could probably get some numbers for you, sir. I will ask if some research can be done.

[Information supplied for the record follows:]

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690

Metropolitan Life
AND AFFILIATED COMPANIES

Philip Briggs
Vice-Chairman of the Board

The Honorable Edward M. Kennedy
Chairman
Senate Labor and Human Resources Committee
428 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy

During my testimony on June 24th before your Committee hearing on health care legislation, you inquired about the amount of the "cost shift" of uncompensated care costs to private employers who currently provide health coverage for their employees. My response at that time may have been unclear, and I would like to take this opportunity to clarify my remarks.

As you know, current studies estimate that in 1986 the cost of uncompensated care was about $8 billion, or about 5 percent of gross health care revenues. This cost includes all costs associated with hospital bad debt and charity care. Although hospitals meet some of this expense through philanthropic contributions and budget surpluses, most of the cost of uncompensated care is shifted to paying patients. Neither Medicare nor Medicaid pays a significant share of uncompensated care costs. Consequently, private sector payors shoulder this burden. Because of the prevalence of employer-based coverage, employers that provide health insurance benefits pay most of the shifted $8 billion.

In the past, the uncompensated care problem was exacerbated by payment methodologies employed by Medicare and Medicaid programs. This is no longer the case. To a large extent this was alleviated by the implementation of prospective payment systems. Consequently, it is fair to say that almost all of the $8 billion in uncompensated care costs is generated from patients who are uncovered by any health program, public or private, and shifted to employers who are providing coverage.

Further, as you requested at the hearing, we will carefully study the proposed minimum benefit package as well as the proposed regional plan design. When we complete our analysis, we will provide you and your staff with our detailed conclusions.

Moreover, we will also carefully review the cost containment provisions outlined in the legislation so as to assure that health care providers join with all of us in assuring that the uninsured receive cost effective health care.

Lastly, we will share with you our views for the role of Medicaid in addressing those uninsured who fall below the poverty lines.

Sincerely

July 1, 1987
PB:gc

bcc:Mr. Allison, Mr. Porcaro

The **CHAIRMAN**. Fine. So it is certainly not an insignificant amount, is it?

Mr. **BRIGGS**. Oh, no. We are talking about a quite significant amount.

The **CHAIRMAN**. Is it your sense that that amount will go down, or will it go up? What has happened in the recent time?

Mr. **BRIGGS**. I am afraid that the trend is up, sir, and I do not see anything to change that trend. I think there is a tendency for more and more people to be uninsured and for that burden to become greater.

The **CHAIRMAN**. And that burden falls on employers who have more comprehensive programs.

Now, S. 1265 requires employers to purchase health insurance. From an insurance perspective, what would you expect to happen under this bill if we did not include a mandate and the system remained voluntary?

Mr. **BRIGGS**. Well, I really do not know, sir. As I said in my testimony, we have very mixed feelings about the mandating aspect of this. We wonder whether we have tried all the alternatives to mandating which perhaps might be tried or considered.

I think we have to do some more thinking about what those alternatives might be and how effective they might be.

The **CHAIRMAN**. We are at least open in terms of the incentives. We have tried to make a level playing field for the smaller business, the owner-operator, and we are looking for some of the incentives that you might indicate to us. But I am very much concerned whether, even with those incentives, we are really going to reach the kind of coverage which is needed.

You criticize our benefit package as being "too rich". I think you were in here earlier when we heard from some of our colleagues, and I have heard from a number of mine, that we are not providing for alcohol, we do not provide for drug abuse, we do not provide for mental health—all things which I believe are important areas of need. We are trying to keep it a bare-bones package. But you indicate that you believe ours is "too rich" and you also suggest that over time, the cost for insurance under the bill could be kept at about the same level of inflation.

In light of almost two decades of experience to the contrary, what gives you this sense of optimism?

Mr. **BRIGGS**. Well, sir, I do not think in my testimony that I said we could keep the cost down to the level of inflation. I think in fact it would be very difficult to do that. I think with the aging of the population, the improvements in technology, it is nearly inevitable that our bill for medical care costs is going to go up at a rate higher than inflation.

I think that the problem we face with regard to mandating the costs is that we are going to be faced with serious additional costs for many of the smaller employers, as we have heard earlier in this testimony.

I think the problem has to be resolved as to whether this is an affordable cost. So it is with that in mind that I want to be sure that the plan is indeed a minimum plan. I am not quite sure where the minimum is.

One of the aspects which I think certainly bears looking at is the 80 percent cost allocation to the employer. That is a substantially higher percentage, sir, I think, than on many, many plans existing today, and I think at least that aspect of it should be reconsidered.

The **Chairman**. Mr. Beadle, you made a number of very specific recommendations in your proposal, and we will certainly take the opportunity to examine those.

You drew a distinction between the mandated coverage, which you viewed with concern, and mandated benefits, which you strongly oppose. Would you elaborate on the distinction?

Mr. **Beadle**. Yes, and I think it addresses in part the question you just addressed to Mr. Briggs, Mr. Chairman.

Our principal concern is that once any specific benefits are outlined in the bill, it limits the effectiveness of the employer, and his local union if there is collective bargaining, in sorting out those benefits that would be most cost-effective and in fact implementing those cost containment measures that would be most effective in controlling costs. And we are very concerned that once any specific benefit is included in the bill or in the regulations, it will just start a long line of interest groups who will feel their cause is quite legitimate. We have already gone through two or three here today, and there will be many, many more that come along. The more that are added in, and the more initiative that is taken away from the local firm and the local employees to determine what the best use of those health dollars is, the more we will see rising health care costs. So it becomes a matter of great concern to us.

The **Chairman**. We tried to address that by requring only the bare-bones package and then permitting the kinds of built-in programs, based upon the employer and the employee. But I understand what your point is.

Mr. **Beadle**. And I might add, Senator Kennedy, you have done an outstanding job in that respect. We are really very impressed with it. We are just concerned to keep it there.

The **Chairman**. Yes. If you were satisfied that the incentives were not sufficient, would you care to comment whether you would support mandated coverage?

Mr. **Beadle**. The whole notion of mandating, of course, is something that all of us have a great deal of concern about. We have tried incentives, and incentives have certainly worked for the larger employers; maybe 85 percent of the work force and their employers have responded to the incentives of tax-favored contributions and benfits.

We still have not fully extended those tax-incentives to all the groups that we are talking about—the small employers, self-employed, for example. And I have wondered if in addition to that we have looked at whether there is some form of modest penalty that might be imposed for those who do not have a plan, that still leaves the decision to them, leave some option to them as to whether they pay an excise tax or some reduced tax deduction, if they do not have a plan; and they avoid that penalty plus receiving the normal deduction if they do have a plan—just a few more areas, perhaps, that could be explored to see if we could avoid the mandating requirement.

The **Chairman**. The problem, that I think we heard the problem very well-stated earlier this morning from Karl Bays, who indicated in his response to a question from Senator Quayle that he supported him basically philosophically, with the exception of this area, pointing out that—and I think the panel generally observed—that we have gone through a period where we talked about a large Federal program, which might have been the national health insurance of several years ago. Then we went to State-mandated programs. We have seen these develop in a few States. And we hear your concerns about that not being acceptable.

And now, we see an increasing number of people who are uninsured, and we hear Mr. Briggs talk about the cost shift just from Medicare, equally about $6 billion, and that is only a part of it.

So what we are trying to do in a way is to keep the Federal Government out, give some assurances in terms of the fairness of the playing field, and make sure we are not going to exclude the millions of people who need some kind of coverage.

Maybe we can provide some incentives. But once we provide incentives, then we are getting into tax expenditures, which increase the deficit.

So as we have been trying to thread this needle over a period of years we get caught in this whipsaw, as you are very well aware, and there are always reasons why we cannot take steps, and we are not taking them, and the problem is getting greater in terms of the needs of people. And that is what we are faced with in trying to balance these various points that you make here this morning against what are the very, very legitimate and increasing needs of a major group in our population.

I want to thank you——

Mr. **Beadle**. I think, Senator, what you have done with this bill and with the prospect of mandating is to make us all get a little more serious. I think there is much more thoughtful consideration given to both the plan and the alternatives than there has been in a long time, and we among others are ready to cooperate with your people in every way we can to try and refine that.

The **Chairman**. Well, you have been very constructive in getting us here, and we are very, very interested in getting your ideas and suggestions.

I thank you very much.

Mr. **Briggs**. Mr. Chairman, if I could just add, there was a very interesting editorial, which you may or may not have seen, in "Business Insurance" on June 8, 1987. It is a very interesting editorial about your proposal, and I would like to suggest that that be included in the record.

The **Chairman**. Yes. You are very nice to mention that one, and it will be made a part of the record.

[The editorial referred to follows:]

8 / *business insurance*, June 8, 1987

opinions

Talk to Kennedy

WE'RE ENCOURAGED by the revisions Senate Labor and Human Resources Chairman Edward Kennedy, D-Mass., has made in his latest proposal to require employers to offer group health insurance plans (*BI*, May 25; June 1).

For months, Sen. Kennedy had been saying that employers would not have to offer a "Cadillac" plan, but provide a bare-bones package to give employees protection from catastrophic health care expenses.

However, the initial minimum health care plan drafted by Sen. Kennedy's staff and circulated earlier this year was anything but bare-bones. With annual deductibles, for example, of $150 for individual coverage and $300 for family coverage, such a minimum mandated plan would have been more generous than plans currently offered by many employers.

Such low deductibles would force thousands of employers with well-designed, generous plans to needlessly overhaul their health care programs.

And, such unrealistically low deductibles also could exacerbate medical care inflation, because employees—who would be picking up few costs—would have little incentive to use health care services wisely.

But in legislation unveiled last month, Sen. Kennedy now is proposing much higher annual deductibles of $250 for individual and $500 for family coverage. Even with the recent trend toward more employee cost-sharing, most corporate health plan deductibles still are below the levels proposed by Sen. Kennedy.

The new package also raises the maximum annual out-of-pocket health care expenses that an employee would have to pay to $3,000 from $2,000.

Sen. Kennedy has made it clear that employers will be allowed to design their health care plans to meet the specialized needs of their employees so long as the overall value of the plan is not reduced. For example, a company could require higher deductibles than the proposed minimums if it enriched the plan in other ways.

Best of all, the Kennedy proposal would preempt state benefit mandate laws. Such laws have become an administrative nightmare for employers operating in multiple states and interfere with the right of employers and employees to decide on the specifics of a health care benefit package that best meets their needs.

With 37 million Americans lacking health insurance, Congress will do something to increase access to health care coverage—the political pressure is that intense.

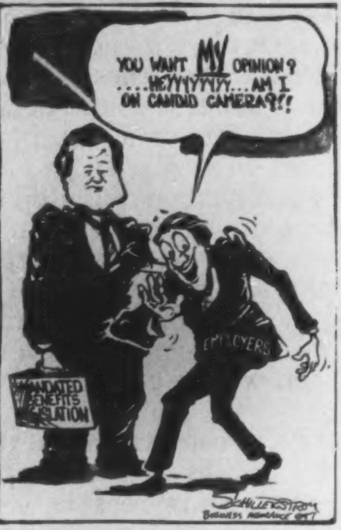
Even with the recent changes, however, we're far from ready to endorse Sen. Kennedy's proposal, which carries a $25 billion price tag.

As we recently noted, there are other alternatives—including expanding health insurance programs for the poor, financed by general tax revenues—to consider and implement before Congress forces all employers to provide health care benefits.

But, we don't believe that employers can afford to blindly reject the Kennedy proposal on ideological grounds that benefits are voluntary and should not be mandated by the federal government.

While a federal benefit mandate may be distasteful, it is far less objectionable than other proposals Congress has been considering, including employer-subsidized health care pools for the uninsured.

The pool proposal, in effect, would make employers with health care plans pay twice—once for their own employees and once for individuals covered by the pools. The Kennedy approach avoids that inequity.


YOU WANT MY OPINION? ....HEYYYYYYYY...AM I ON CANDID CAMERA?!!
EMPLOYERS
SCHILLERSTROM
Business Insurance ©87

Employers have to recognize that Congress is not going to sit by while 37 million Americans lack health insurance. Congress will do something to increase access to health care coverage—the political pressure is that intense.

Sen. Kennedy's staffers have made a point to open their doors to listen to input from the business community before drafting legislation. That open-door policy, in sharp contrast to the closed doors behind which many benefit issues have been decided in Washington, clearly has produced a better proposal.

Employers, even those that oppose federally mandated health insurance, should take advantage of the open door Sen. Kennedy is offering. Such input can help produce a better legislative product. And that is in everyone's interest.

We would be the first to point out that the Kennedy proposal, as currently drafted, has a number of flaws that should be brought to the attention of Sen. Kennedy and his staff.

For example, Sen. Kennedy is proposing that employers generally would have to pick up 80% of the group premium for both individual and family coverage. Even at companies with generous health insurance plans, employees typically pay a greater percentage of the premium for family or dependent coverage than Sen. Kennedy is proposing.

Undoubtedly, many employers, especially smaller firms, would have difficulty paying such a high percentage of the premium.

But employers will find it difficult to recommend changes if they aren't part of the legislative debate. Employers should recognize that lobbying involves far more than simply opposing or supporting a bill.

The most effective and important lobbying often is convincing legislators to make an objectionable bill less objectionable.

The **Chairman**. Other Senators may have questions.

Senator **Weicker**. I have no further questions at this time, Mr. Chairman.

Senator **Dodd**. No questions, Mr. Chairman.

The **Chairman**. Thank you very much.

Senator **Weicker**. Our next panel includes representatives of a number of business associations. Willis Goldbeck is President of the Washington Business Group on Health, and a respected and knowledgeable spokesperson on the issue of business and health.

Bob Patricelli is the President of Value Health, Inc. and is speaking on behalf of the United States Chamber of Commerce. He is the Chairman of their Health Care Council.

Gerald Rudd is Senior Vice President of Albertson's Incorporated and is appearing on behalf of the Food Marketing Institute.

And Mark Ugoretz is the Executive Director of the ERISA Industry Committee, an influential voice on pension and welfare issues.

Gentlemen, it is nice to have you here, and we will go in the order that I announced.

Mr. Goldbeck, why don't you proceed?

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC; ROBERT E. PATRICELLI, PRESIDENT, VALUE HEALTH, INC., AVON, CT, AND CHAIRMAN, HEALTH CARE COUNCIL, U.S. CHAMBER OF COMMERCE; GERALD R. RUDD, SENIOR VICE PRESIDENT FOR HUMAN RESOURCES, ALBERTSON'S INC., BOISE, ID, AND CHAIRMAN, BENEFITS COUNCIL, FOOD MARKETING INSTITUTE, WASHINGTON, DC; AND MARK J. UGORETZ, EXECUTIVE DIRECTOR, THE ERISA INDUSTRY COMMITTEE, WASHINGTON, DC

Mr. **Goldbeck**. Thank you very much, Senator. It is a pleasure to be here with you.

Some employers will oppose any mandated approach, and some of those would be in the WBGH as well. But we are not here today to oppose this; we are here because our membership has instructed us to continue a process which began several months ago, of very constructive dialogue with the staffs of this Committee and the respective sponsors of this legislation, whom we feel have been incredibly responsive to the needs and interests of our membership and of the business community generally.

I would note that Chrysler and American Airlines are WBGH members and have spoken individually this morning. It seems to me that it is our responsibility to try and make S. 1265 a good building block for the health care of all Americans.

The problems addressed by this piece of legislation are very real and appropriate for Federal intervention. No one can deny the negative impact on this nation, internationally as well as domestically, of having an increasingly large portion of the population going without health care protection.

Alternatively, the impact is just as negative when some worker's health protection comes by the indirect charges to those employeers who already are paying appropriately for the care of their own workers and their families.

We have not been successful in using incentives to close the final gaps on the progress made in the employment sector as a provider of health insurance. But it would be equally wrong to suggest, as some others have done already today, that this kind of legislation is a guarantee to close down America's small businesses. The majority of America's small businesses have proven their capability and willingness, voluntarily, to provide health insurance, a lot of it at or above the magnitude suggested by this piece of legislation.

To say that requiring somebody else to do precisely the same as their competitors have already proved capable of is simply not consonant with the idea that they would automatically have to go out of business.

The biggest threat to U.S. competitiveness is the failure to take care of our own citizenry, not to have employers provide responsible benefits for employees.

Yes, S. 1265 is a tax, and it does change a benefit to an entitlement. But it does not mandate the benefit structure as the State mandates now do. And I would concur with the comments you have just heard from Mr. Briggs and others that there is a very important distinction between mandated coverage and mandated benefits.

There is probably nothing more important that you have heard in the entire day than the distinction between the movement toward government as provider of services versus government as setting a standard for a responsible standard of benefit in the private sector where the dollars can remain. You are dealing in effect with an economic transaction between local employers and employees and the sellers of service in the health care industry.

There is not one WBGC member who would not prefer that, with or without a mandate, to having government respond to public pressure to assume a greater responsibility by becoming the direct provider of those specific medical benefits and services.

Our written statement contains a wide variety of technical comments on all the different aspects of the bill. Let me just mention two or three points.

One is that this legislation provides an opportunity to help all employers by getting rid of a recently adopted, onerous, and unnecessary piece of legislation: the benefit tests for eligibility under the nondiscrimination component of the recently passed Tax Act.

Two, we also believe that the preemption of State mandates will help employers generally across the country without diminishing the responsible protection for those consumers in need.

Three, we believe very strongly that there is a companion necessary to this private sector-oriented bill, and that is to have Medicaid establish a national eligibility standard so that we stop the sham of some States pretending they are taking care of the poor, and poor workers by providing virtually no benefits.

This is by and large the perspective of large employers; that is our membership. We do not purport to represent all kinds of employers, because they are not in the group. But the WBGH is a small business itself, and we know the problems of small businesses, and know full well that small businesses that now provide health insurance voluntarily are those that would be helped most, from the standpoint of equity or competitiveness, by passage of a requirement such as that contained in S. 1265.

This is not, as some suggested earlier this morning, a disemployment bill. American industry has accomplished massive disemployment over the last 6 years without the help of any mandates pertaining to health insurance, and that has been viewed as a positive step in making this Nation once again more competitive.

It is entirely unrealistic to suggest that this bill would cause the same disemployment that has taken place already.

Let me close by saying to you that we feel that the Committee staff and the sponsoring Senators, have given a great opportunity here for the business community to be heard. This is not the posture that always was received from this Committee in the past. We believe strongly that it is the responsibility of those of us in the business community who care about these issues, who care about the degree to which the public is fully protected, who care about access to reasonable health care, that continuing to work with the Committee is exactly the posture that ought to be taken.

Fixing the employment-based distribution system is entirely preferable to constructing a government-based distribution system.

Thank you very much.

Senator **Weicker**. Thank you very much, Mr. Goldbeck.

[The prepared statement of Mr. Goldbeck and responses to questions submitted by Senator Kennedy follow:]

Washington Business Group on Health

THE MINIMUM ESSENTIAL HEALTH CARE ACT

U.S. SENATE COMMITTEE ON
LABOR AND HUMAN RESOURCES

TESTIMONY PROVIDED BY THE

WASHINGTON BUSINESS GROUP ON HEALTH

Willis B. Goldbeck
President

June 24, 1987

Statement prepared by:
Cathy Amkraut
Carol Cronin
Willis Goldbeck

229½ Pennsylvania Avenue, S.E. Washington, D.C. 20003 (202) 547-6644

My name is Willis B. Goldbeck, President of the Washington Business Group on Health. It is a pleasure to appear before you today to discuss the reactions our members have had to your bill, S.1265, the Minimum Essential Health Care Act.

As you are aware, our members are the nation's very large employers, 100% of whom have voluntarily provided extensive health insurance benefits, often as a component of labor union negotiated compensation contracts.

ON-GOING COOPERATION, NOT BLIND OPPOSITION OR SUPPORT NEEDED:

Let me say at the start that we are here to contribute to the on-going development of the legislation you have proposed. While we do not currently endorse the bill, neither are we here to oppose it. We want to very clearly recognize the thoughtful and cooperative efforts made by Senator Kennedy and his staff as our members have provided recommendations over the past few months. We believe this bill is attempting to address real needs that are appropriate for federal intervention. Further, we believe the bill's authors and sponsors have been sincere in their efforts to create the least possible disruption to existing, voluntary, employer and labor health insurance plans.

Whether or not we eventually support or oppose the final bill, it is certainly significant that our members and Board approved our recommendation not to oppose the bill and to keep working on its improvement. Although it may be easier and more traditional to take a simple yes or no position, we feel the more responsible and useful stance is one of a continuing joint effort toward an acceptable solution to problems that are of national scope.

FOCUS ON PROBLEMS, NOT PARTIAL SUCCESSES:

It is easy to speak of the millions who have excellent health insurance and the many others who, regardless of coverage, actually receive excellent medical care. However, to do so merely shifts the focus away from the real problems which are the driving force behind Congress' renewed interest in health insurance issues.

Since the 1930's, and especially during the 1945 - 80 period, we built a medical care financing system on two basic principles:

1. Everyone should have access to quality medical care when needed, and
2. Employers should be the primary distributional vehicle for financing that access.

While the growth in employee benefits supported the first point, employers have also always supported the second as distinctly preferable to any of the more government-oriented national health insurance proposals. This brief historical note is important because it makes clear that the USA has been developing a national health system, with the consensus of the business community, for a long time. Our points of difference have been over the role of government, not the policy goal. This remains true today. However, conditions have so changed during the last few years that the re-examination of responsibility which S.1265 represents is entirely appropriate.

An assessment of the acceptability of S.1265 must begin with an honest recognition of the problems we face:

1. There are approximately 37,000,000 individuals with no health insurance, a trend that has been rapidly escalating after a decade of reductions. Two-thirds of these uninsured are workers or dependents of workers.

2. Another 7-15 million are so inadequately insured that no business or congressional leader would consider them reasonably protected.

3. In 1982, the Robert Wood Johnson Foundation found that approximately one million Americans were denied access to needed care, in that year, due to their eligibility_ to pay.

4. Medicaid defines eligibility at or below 50% of the federal poverty level in 30 states, thus denying the right of access that was promised the poor. Some 500,000 people per year exhaust all their assets, for the privilege of gaining Medicaid eligibility, and thousands of couples must get divorced to have government subsidized coverage while retaining enough assets for a noninstitutionalized spouse to live.

5. Medicare fails to provide any meaningful protection for the chronic long-term care needs of its constituents while increasing the cost to beneficiaries of the acute-care services.

6. Medical care costs are escalating at their highest rate, in relation to the rest of the economy, in modern history thus making it less and less possible to purchase even modest insurance.

All of these problems are exacerbated by our great successes with extending longevity, new technology that creates new expenditures and special categories of new patients (such as "technology dependent children" who previously did not survive), and new diseases such as AIDS that, not having any cure, challenge us to redirect resources toward prevention and humane maintenance.

Just as business must seek federal policy which does not impose unreasonable barriers to successful competition in international labor markets, so too business must recognize that access problems of the magnitude described above represent a threat to the total economic and political stability of the USA.

When looking toward employment as the distributional mechanism for health care financing, several work-related changes must be considered.

1. The trends in benefit design are away from first-dollar coverage toward greater financial participation by the beneficiary. This change has not lead to any reduction in access; cost sharing is still rather low, and employees are starting to become more informed users of their benefits.

2. Much of the increase in uninsured workers comes from changes in employment patterns:
    a. Workforce reductions to increase efficiency;
    b. Increased early retirement;
    c. Increased use of part time and leased employees;
    d. Mergers and acquisitions that included reduced workforces and benefits as part of the deal;
    e. New employment is predominantly in small business and the service industries, both of which are traditionally associated with relatively low benefits.

Some of these developments are very good for the US economy, while being bad for individual workers. Some, such as part-time work, is a valuable trend, especially for older workers and working mothers who are finding new job opportunities...a trend that will invariably increase due to the absence of young workers for the next twenty years.

Other factors, such as mergers and bankruptcy laws, are economic and legal realities that are beyond the scope of any benefits legislation but significantly impact the provision of health care to workers.

3. Much has been made of the success of our economy in recent years for generating new jobs. At issue here is not the number of new jobs, but rather the characteristics of those jobs versus the jobs lost during the same period.
   a. Whereas only some 20% of new jobs used to begin at or below the minimum wage level, more than 40% of the new jobs created in the past few years have been at this level.
   b. During the past three years, jobs lost earned an average of $444 per week and were in relatively high benefit industries. New jobs, during the same period, earn only an average of $218 per week and are far more often in low or no benefits positions.

These two points indicate that the government's traditional anticipation that most new jobs would come with voluntarily provided health insurance benefits is no longer valid.

CHANGE VS. STATUS QUO

There can be no denying that S.1265 will cause some economic hardship for some employers. Our efforts to work with Senator Kennedy and his staff are focused on finding a reasonable balance between the cost of change and the cost of the status quo. Employers' assessment of S.1265 should not be isolated to the bill itself but must also consider the costs now incurred due to the absence of such legislation.

Every employer who does not provide health insurance hurts those who do. Dependents whose spouses company does not provide health insurance have their care subsidized by the employers who do have dependent benefits. Uncompensated care is a misnomer for transferring the cost of care to another payer. Every state insurance pool is simply a political device to charge those who have coverage with the cost of care for those who do not, a device in the absence of the political will to allocate general revenues for the task, or to require coverage by those employers who have avoided the obligation thus far. All these cross-subsidies are, in effect, taxes. One of the concerns about S.1265 is that its mandate is also a tax. Employers are experiencing the transition of health insurance from an employee benefit to a public entitlement that is distributed through our system of employment. The taxation value of this development is partially offset, at least financially, by the pre-tax use of benefit dollars and the deductability by the employer.

You will undoubtedly hear from those who say small business cannot afford health insurance. We commend to your attention the Small Business Administration Report that 46% of firms with 1 - 9 workers, 70% with 10 - 24 workers and 92% with 25 - 99 workers already voluntarily offer health insurance. It is these small employers, (like the WBGH itself) who are also unable to avoid state mandates through ERISA preemption, that stand to be treated most equitably by S.1265.

BASIC PRINCIPLES:

WBGH members, separately and through a variety of committees, have identified the major provisions which any mandate bill would have to contain.

This list is offered fully recognizing that, for some employers, no mandate will ever be politically acceptable.

1. A Real Minimum Benefit
   The benefit must really be a minimum. This is probably the most difficult issue since it requires a major philosophical shift to accept the notion of Congress supporting a health care entitlement that was less than optimal or even equal

with the norm of our society. In fact, this would not be a new attitude. Public housing and food stamps would never be confused with national norms in shelter and food but both have long histories of Congressional and public support.

The key to progress in the distribution of health care access through employment is to get all employers doing something, making the investment decision with their employees to provide a basic level of protection without reliance on public programs or cost shifting by providers to the bills of those employees who are insured.

2. Non-Discrimination

The non-discrimination eligibility tests for health benefits, as passed in the Tax Reform Act of 1986, must be greatly amended or eliminated. Especially in the context of S.1265, the nondiscrimination requirements are a generally useless and very expensive responsibility for employers. Relief from this mandate will, quite appropriately, increase the likelihood of business support for S.1265.

3. National Medicaid Eligibility

The federal government needs to take a dramatic companion step to S.1265: nationalize the eligibility standards for Medicaid. Such a change would be a fitting companion to the proposed new requirements on employers. The public and private sectors must make integrated adjustments if lasting progress is to be achieved. It remains appropriate for the costs of Medicaid to be shared and for the states to have flexibility in benefit design to meet local needs. However, it does not make sense for states to use the eligibility standard as a gimmick to exclude the poor from their benefits. All states should be required to use the federal poverty level as the lowest eligibility standard and to allow people to buy into Medicaid, on a sliding scale, until they reach 20% of federal poverty. This proposed change in

Medicaid would also be a great help to low income workers changing jobs. Without this proposed Medicaid improvement, workers would have minimum coverage from their employer but could fall through the cracks when between jobs. The importance of this recommendation is underscored by a recent Syracuse University study which estimated that 45% of AFDC recipients who lost Medicaid coverage due to 1981 cuts targeted at those with earned income failed to acquire alternative health care coverage and experienced significant declines in their use of basic health services. Even inpatient hospital use declined by 71%, leading to unnecessary medical complications and more costly future treatment.

4. COBRA Revisions

The COBRA obligations need to be revised, if not eliminated. The goal of S.1265 is that employers must become responsible for employees. The extent to which that responsibility should be extended to a wide range of non-employee groups should become the subject of a full scale re-examination that reflects the changes of responsibility imposed by S.1265. Employers who have volulntarily extended benefit protection to many non-workers--as many WBGH members did long before COBRA--should be given credit for that contribution, rather than being penalized as though they had done nothing of social value.

5. Medicare Cost Shifting

It is equally essential that Congress and the Administration stop pretending that shifting costs from Medicare to private employers is a "savings." An example is the Medicare Secondary Payor programs which require employers to be the primary source of coverage for many Medicare eligible beneficiaries. In fact, these shifts, which have gone on for six years and are projected, in the Administration's budget, to be billions more in the next five years, are nothing more than a tax increase without having the political fortitude to say so. As employers are asked to accept a mandate, the Congress must accept its responsibility to finance its Medicare obligations.

6. Federal Pre-emption of State Mandates

The federal overide of state mandated benefits is one of the most significant features of S.1265. State mandates, which now number in excess of 600, have several disadvantages:

a. More than anything else, they are the method that specific provider groups have chosen to avoid having to prove the actual value of their service in the medical market place. This is contrary to either good economics or sensible health policy.

b. Another source of state mandates has been the desire to provide financial protection from the costs of specific illnesses. While we can be far more sympathetic to these concerns than to providers seeking a government protected franchise, this is still bad policy. Privately provided employee health benefits should not be subject to redesign by every state legislature that wants to appear to heed a social insurance need at no cost to their own budget. For the advocacy group, often legitimately desperate in their search for help, the mandate is a shallow victory since it gives the appearance of protecting everyone when in fact only a small portion of the state's populace is covered by employers who come under the mandate.

c. Each new mandate provides a valid excuse for small employers not to provide benefits in the first place.

d. The ERISA preemption for self-insured employers means that, in many cases, the only employers who have to shoulder the costs of mandated benefits are those firms which provide health insurance to which the mandate can be attached.

e. From the perspective of our members, which are large firms, many of which are located in 30 or more states, a single, uniform, federal mandate is preferable to the multiplicity of state mandates. State pools, an often discussed alternative, are even less attractive to most of our members.

f. Finally, to the extent that the impact of mandated benefits is seen as a factor in international economic competitiveness, our only responsible and practical response is to delegate the authority for mandates to the federal level where such international impact can be assessed.

PRACTICAL CONCERNS AND RECOMMENDATIONS

In no particular order, here are a variety of reactions pertaining to specific aspects of the bill as now written, and to the theories the mandate approach represents.

No bill will make all employers happy or impact them all equally. Some companies gain an economic advantage under today's rules because many of their workers elect to be covered under the insurance plan of their spouse who works for a different company. Under S.1265, some now so advantaged would become disadvantaged. This will always be the case unless the US adopts a single model of governmental social insurance....an approach that is opposed by virtually all employers.

Some of the employer opposition to mandates is based on the "foot-in-the-door" theory. And, you must appreciate that there exists ample historical justification for this concern. Recent comments from congressional representatives that the employee-paid leave proposed in the parental and medical leave bills is just a first step to an employer-paid mandate would be a current example.

Your bill represents an expression of public value that health insurance has become so basic to the fabric of our society that it cannot be left to the marketplace. The alternative that would take health care completely out of the marketplace is totally unacceptable. Therefore, we all must make accommodations to other alternatives which can support the role of the market while increasing the societal value and equitable distribution of tax subsidized employee health insurance. The fact that the average US male worker's wage fell, in real income, nearly 10% between 1975 and 1985 only adds to the pressure for guaranteed access to affordable health insurance.

1. We support:
    a. The catastrophic-level-only plan requirement for new employers and those with less than ten employees.
    b. The increase from 25% - 100% business expense tax deductability for the health insurance premiums of self-employed persons.
    c. The use of regional insurance pools on a private-sector competitive basis.
    d. The flexibility given employers to have any combination of deductables, co-payments and co-insurance that stays within the total provided for in S.1265; and the benefit flexibility provided within the constraints of actuarial equivalency.
    e. Inclusion within the monthly actuarial rate determination of administrative costs and a contingency margin.
    f. The allowed use of HMO-PPO plans without indemnity plan options.
    g. The requirement to have stringent control over Congressional demands for additional benefits.
    h. The requirement that every employee accept the coverage of their own employer.
    k. The extension to 180 days of the period before benefit eligibility for new workers. The new worker must be

allowed to buy into the company plan thus meeting the Congressional goal of access but the plan design would respect the reality that an amazingly high rate of turnover exists (up to 50% in some companies) in the first six months.

2. Major Unresolved Problems:
   a. Dependents

      Based upon preliminary analysis by many WBGH companies, the costs of your plan are reasonable for the employees but can be very high if the same requirements are extended to non-working dependents. Recognizing the policy goal you seek to achieve, and preferring private rather than public-sector programs, it would seem that your goal could still be accomplished if some additional dependent cost sharing were allowed and/or if COBRA requirements were removed. It should be noted that in companies where there is now a cost-sharing differential for families, the vast majority still do accept coverage. Furthermore, an employed child should be covered by his or her employer and not allowed the option of chosing their parents' plans.
   b. Child Care

      For most large employers this is a major new expense required by S.1265. Our members are generally willing to accept the prenatal care requirement because studies show this time-limited benefit to be a wise investment. However, the open-ended and totally undefined well-baby care requirement is not acceptable. Further, allowing the Secretary of DHHS to change this benefit annually contradicts your very well conceived approach to limiting future benefit additions.
   c. Actuarial Benefit

      This is not an easy task. Throughout the mid-1970's, both government and the private sector tried to create an equivalency table, to no avail. It will not be easier today. The Department of the Treasury has been at work on this problem for several months as it seeks to provide regulations for the new non-discrimination provision.

The WBGH has organized a task force to work with Congressional staff on this issue. One of our objectives is to be sure that the expenses or savings of cost management programs do not get counted in any way that would serve to inhibit their use.

d. Pre-Existing Conditions

There is no way to retain the private sector system of commercial insurance and totally disallow pre-existing condition clauses. Exclusions from a plan may not be justified but limits of a definite period for specific conditions certainly are. However, the time limits for pre-existing condition inclusion should be based on current insurance and self-insurance practices reflecting the basic financial premise of an insurance program. So saying does not recommend acceptance of either exclusion or limitation based on estimates of risk. That is an issue which should not be confused with the matter of pre-existing conditions.

e. Damages for Individuals

We are very concerned that the provision to make employers liable for damages to individual employees will result in a mass of unnecessary litigation. The bill contains ample enforcement procedures through the Civil Money Penalty Act. This will protect against employers who make an effort to evade the law and your provision respecting the degree of good faith effort to comply is strongly endorsed. However, we feel that the individual damages provision is an unwarranted invitation for an economically at risk employee or dependent to bring suit under this provision in search of a settlement having nothing to do with the entire health insurance issue.

f. Hourly Wage Rate

We do not support the $4.19 "health minimum wage." This would set a separate minimum wage for the administration of this health benefits law which would be extremely costly and difficult to administer. Considering the growing proportion of workers in these low-wage categories, it is very important that all federal policy use the same minimum wage rates.

g. Definition of Diagnostic and Screening Tests

The extent of "diagnostic and screening tests" must be defined. Otherwise, every unwarranted annual physical and unnecessary genetic screening gimmick will become a mandated benefit. These are not "minimum" standards and in fact, often lack any science standard at all.

3. We Recommend Further Examination of the Following Issues:

   a. An increase in the number of hours which constitute part-time employment from 17.5 to 25 or more. The Bill should allow pro-rata contributions based on hours worked below the 40-hour full-time level and allow employers to create a system to account for fluctuating work schedules.

   b. We do not understand why an employer who meets S.1265's requirements through a regional plan must remain with that plan. It would seem that those plans would do a better job, both economically and in terms of consumer satisfaction, if they were subject to the normal market pressure of competition. If an employer starts with a regional plan but, a few years later, can meet the bill's requirements while getting a better deal elsewhere, we find no logical explanation for not allowing that employer to switch plans.

   c. Federal legislation should remove any federal (and pre-empt any state) barriers to the aggregation of "non homogeneous" employers for the purpose of joining or creating insurance pools.

d. That the effective date for this Act be one full year after the publication of final regulations. As we have learned repeatedly over the past few years and are now experiencing with COBRA and non-discrimination, there is mass confusion and major unnecessary expense incurred when a law becomes effective before its regulations are provided. By this recommendation, we hope to encourage Congress to press for a reasonable rate of regulation development since your goals will be delayed as a long as the regulations are delayed.

e. While we do not believe the Act should make any exceptions for state mandated mental health benefits, we also do not believe the Act should explicitly exclude mental health coverage as it does in Sec. 312(a)(1)(2). It is no more appropriate to exclude care of the brain than it would be to exclude care of the heart, hip, neurological or muscular systems.

f. Cost management is a national policy objective of Congress as well as private employers. S.1265 needs to be cautious not to change employer cost management criteria while imposing mandates which run the risk of escalating health care costs to even more unacceptable levels. Many employers have found that the best way to secure employee and dependent acceptance of cost management rules (such as second opinion and pre-certification requirements) or cost effective providers (such as a PPO), or life-style improvements (such as smoking cessation) is to provide incentives tied to reimbursements. The cost sharing limits in S.1265 should not include these cost management incentives since any costs to the beneficiary will be the direct result of their own decision to pay more rather than follow or utilize the cost management provisions.

g. S.1265 provides one more justification for the elimination, by regulation or legislation, of the employer's equal contribution requirement under the HMO Act.

h. S.1265 protects the consumer by providing for indexing of the stop-loss levels of the plan. We believe it would be good economic policy to index the cost-sharing provisions on the same basis.

i. Employers should have the right to automatically deduct plan contributions from the wages of any employee who refuses to submit a plan election form or provide evidence of alternative coverage for a spouse. Due to the penalties on employers for non-compliance, this is the only way for the employer to protect both the company and the employee/spouse.

j. With so much of the plan based on wage determinations, what are employers to do about workers whose compensation is largely commissions and bonuses?

k. Medical necessity is normally included in a contract in private-sector plans and certainly belongs, as you state, in S.1265. However, you need to provide language specifying how, and by whom, this determination of necessity is to be made.

l. Flexible benefit plans are a growing option for even mid-sized firms. S.1265 needs to be designed to respect this development. To do so can be as simple as requiring every employer to offer one plan that meets the federal minimum while allowing other plan options to include different flex benefit contributions. Some of these plans may, overtly or through the allocation of plan credits by the employees, involve greater than the federally established cost-sharing maximums. The point is, as long as every employee has the option of accepting the federal minimum plan, we believe public policy is well served by also allowing them the freedom to pay more for health insurance if they personally desire to trade for more of another benefit. Even other health-related benefits such as wellness, child care, and long-term care can be in the flex plan trade-offs and it would be contrary to the spirit of S.1265 to exclude the employee's option to select such benefits. S.1265 can protect its policy goal and avoid shifting responsibility among employers by not allowing any worker to take a flex plan which does not include health care coverage at least equal to S.1265.

ALTERNATIVES TO MANDATES

Mandates, according to many employers, should be called entitlements rather than benefits. Benefits are something granted by an employer (with or without unions) in return for some value from the employees. When an entitlement is created by government, no matter how justified, it is no longer an employee benefit.

Mandated benefits are never the desired approach for business. They also seem to be a much easier solution than is actually the case. For every mandate there is a price that may not be paid by the social account in quesiton (in this case access to healthcare), but will be paid by other impacts on the economy, on employment, on small business entrepreneurial development, on other desired services not delivered, and on the diversity which is so central a component of the American work and community culture.

If they can be made to work, incentives are always preferable to mandates. Options do exist. The number of small firms that provide health insurance is ample evidence that it can be done. Aggregation of small firms, professional groups, and the self employed are not new, they are just not sufficiently prevalent. The tax deductibility of health insurance is an underutilized tool that can be selectively applied by Congress not only to help the self-employed gain parity with larger firms, but also to reward firms that invest in prevention programs or that join purchasing groups to increase their buying power and cost management options.

To be specific, Congress could declare a national objective of having all employees and their dependents covered by employment-based health insurance by a target date, say June 24, 1997, a decade from today. A graduated business tax credit could be established that would start with the provision, by an employer, of the federally designated (but privately sold) minimum plan. The refusal to provide the minimum would be an employer's right but would result in a tax on that employer to cover the cost of 50% of the care actuarially estimated to be incurred by those employees. I say 50% because that could be established as the national base for employer's contributions.

The graduated tax credit would increase as those employers who did provide insurance added preventive services, cost management systems and more expansive benefits thus reducing the risk to the government (and therefore to the tax payer) of minimally covered employees resorting to public programs.

Special long-term social objectives for which the economic benefit is societal, such as prenatal and well-baby care, could receive special tax benefits.

An alternative or perhaps supplementary approach would be for the federal government to provide financial incentives directly to health plans that sold these benefits at affordable rates to small employers. Other alternatives, such as mixing private insurance with Medicaid buy-in options, also exist.

Any ideas such as these require extensive review and scrutiny by all interested parties. Our point is only to show that the rush to mandates, while understandable and increasingly attractive to many is not the only way to achieve the objective I believe we all hold: access to, and acceptance of, adequate and affordable health care by all working Americans and their families.

Any majôr reorganization of responsibility is tantamount to a review of federalism. Every section of society must be viewed at the same time. All too often we take a sequential approach: one year Medicare "reform", then next a focus on employee benefits with a pledge to get to Medicaid sometime soon. The point is, all the programs are integrated in their cost and service delivery impact whether or not we intended them to be so. Here is one way--not necessarily the best--we might reallocate responsibility:

1. The federal government would be responsible for total care for anyone age 70 and beyond. Medicare, or whatever the program would be called, would include prevention and long-term care: a really integrated package of managed services.

2. States would be responsible for the poor who are 69 or younger. Poor would be defined as anyone below 100% of the national poverty line. Those between 100-200% of poverty would be eligible to buy into the state plan on a sliding fee basis. The costs to the states could be substantially offset by the fact that no "medicaid" dollars would go for long-term care for the elderly and there would not be anyone over 69 who would be eligible for both federal and state plans.
3. Employers would be responsible for an S.1265 type plan for all employees and dependents. COBRA extensions would be limited to people who leave the workplace on company-induced early (pre-70) retirement, and for six months only to the other COBRA categories.

4. Counties would be responsible for local public health programs, a new network of preventive services with a focus on child care, and for special cases that fall through the cracks in 1 - 3 above.

Naturally, there are problems with this system. The point here is only that it is possible to design many alternative approaches to the way we allocate responsibility today. For the long-term economic benefits of America, we will be better off to explore these approaches rather than constructing mandatory entitlements as though they were a separate solution.

Finally, state experiments need to be encouraged. The recent New Hampshire statute establishes a system of health insurance for part-time workers from the 15-hour-per-week level. The Maine, Michigan, and Washington initiatives that assure health care coverage as people move from welfare (Medicaid) to part- or full-time employment and the proposed Wisconsin state health insurance plan are other examples.

CONCLUSION

One of my earliest experiences dealing with Congress on health issues was in 1975, appearing before you to address the Kennedy Mills National Health Insurance bill. At that time, the WBGH was just a few months old and the very concept of employer involvement in health policy was unheard of. Congress could not seem to understand why we felt it was appropriate for us to be there and most employers understood neither the issues nor the potential impact their participation could--indeed would--generate. Today, twelve years later, we meet across the witness table again. So much has changed. Your legislative thrust is built around employers and employers are deeply involved in virtually every health policy debate. What was a schism born of mistrust and the failure to communicate has become an on-going, respectful, and mutually beneficial effort to jointly address national problems. While we may have often disagreed, the fact that we need each other and can work together is no longer in question.

S.1265 has improved the national dialogue and may well hold a key to preserving that uniquely American balance between government espoused social insurance goals and the private sector's ability to deliver on that promise. WBGH is pleased with the progress you have made with refinements in S.1265 and we look forward to working together for a law that serves the dual purpose of solving problems without damaging the substantial success which has been achieved through the voluntary provision of employee health insurance.

Washington Business Group on Health

July 22, 1987

TO: Senator Edward M. Kennedy
Chairman
U.S. Senate Committee on Labor and Human Resources

THRU: David Nexon
Health Staff Director

FR: Willis B. Goldbeck
President
Washington Business Group on Health

RE: Response to questions submitted with Senator Kennedy's July 14th letter

Question 1: **Is it unfair for some employers that do a good job of insuring their workers to [have to] pick up the costs of other people's employees?**

Answer: In a word, yes. But, your question warrants a more complete reply. In the WBGH, we work with the very largest companies. Virtually all of them give significant funds to local hospitals, national health care charities like the American Cancer Society and to universities for medical education and research. In addition, they expect and have never questioned the appropriateness of contributions to care for the poor through taxes that support state programs, Medicaid or Medicare. It is against this background of voluntary contribution that the fairness issue you raise must be viewed. Employers did not expect nor volunteer to be made responsible for the health care costs of workers from competing companies.

In part, this attitude can be called naive because employers who provided insurance should have been more aware of hospital cost shifting. Nonetheless, that problem historically involved rather few from the active workforce. Today, with some 70% of the 37,000,000 uninsured being regular

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workers and their immediate dependents, the problem has become visible, enormous and very unfair. One of the natural reactions is to pass an ever escalating share of the cost back to the employee. In the absence of any mandate to provide health insurance in the first place, it is also easy to see why this unfair shifting of responsibility is causing more companies to simply drop the health insurance benefit.

If health care were a non-essential benefit, like an extra week of vacation, there would be no fairness issue and you could let the marketplace dictate the availability of that benefit. Those who did not get it from their employer could not go to a resort and have the cost charged either to government or to another employer. Just the opposite occurs with health care. The fact that one employer does not provide the insurance does not alter the need for the service, indeed the need is often not a matter of choice at all. Further, the individual may go to the hospital or other care giving facility, consume the service, and then expect some combination of government and cost shifting to pay the bill. The more we, as a society, seek to protect access the more unfair it is, ironically, to those very firms and unions that have performed in the most socially desirable manner.

Question 2: **Do some employers have to pay an unfair share of society's health care bill when someone who is uninsured goes to the hospital, and when a worker elects to have his or her family covered by one employer because the employer of the other family member has either a very low benefit or offers no health insurance at all?**

Answer: The answer to the first part is clearly yes and was covered in my reply to Question 1. Your second point is more complicated, but is central to understanding why some employers like S.1265 which others are in opposition.

Employers, such as auto and steel, that have the most extensive dependent coverage, have always "carried" spouses who work for firms that provide less extensive coverage. In otherwords, the workers behave intelligently and follow the economic incentives placed before them. The same situation applies if a firm employes lots of part-time workers and does not give them benefits.

Typically, many of them will be covered as a spouse of a worker in another company. A third example is coverage differentials even within one industry, such as retail. A fourth example, very typical of Washington, D.C., is for a federal or congressional worker to cover his or her spouse because the spouse's private sector employer has an insurance plan that is either not as good in terms of coverage or is much more expensive than the federal employee's option. S.1265 would reduce economic imperatives now causing many employees to be covered by a spouse's employer. For those companies, like WBGH members Chrysler and American Airlines, it is easy to see why they like this approach. For other firms, including many WBGH retail and financial institutions, opposition to S.1265 is equally understandable because their costs would go up considerably.

Question 3: It is not true that businesses that are at the cutting edge of international competition already insure their workers?

Answer: You are 100% correct for any large U.S. company. Further the differences in total compensation rates between the U.S. and those with whom we compete are decreasing rapidly. And, we really must ask ourselves if we want the pathway to successful competition to be paved by reducing U.S. workers standards of living and basic social service protection to the level of Third World nations.

There is one aspect of your question which deserves special attention. You asked about the "cutting edge". While it is true that the vast majority of small firms that would, have to provide some health insurance due to S.1265, have not one iota of international competition, it is also true that much of our "cutting edge" technology comes initially from very small firms. The recent history of innovation in products, services, technology and even management systems, all essential to long term international competition, is increasingly dependent upon the individual entrepreneur and the small, flexible, efficient business. In many cases, these firms operate at a loss until their innovations -- their "cutting edge" contributions -- cause them to be acquired or deemed worthy for the primary sources of venture funding. Every new financial requirement placed on these individuals and firms carries the risk of reducing innovation. S.1265 needs to recognize that, just as the cry about international competition is nothing more than a smokescreen for many, it is a very real issue for certain special categories of business.

Senator **Weicker**. Bob, nice to see you.

Mr. **Patricelli**. Mr. Chairman, thank you.

I am Bob Patricelli, President of a small business located in Connecticut, and I am very pleased to see our State so well-represented today. And it is perhaps relevant to note that I have served in the past as a Deputy Undersecretary of HEW and as a minority staff member of this Committee.

I am appearing today on behalf of the U.S. Chamber of Commerce, as Chairman of its Health Care Council, and I will summarize my testimony briefly.

Our publicly and privately financed health insurance system is clearly an American success story. It provides coverage for 132 million people through employer-sponsored health insurance, supporting in the private sector the delivery of what is certainly a public good and avoiding what would otherwise be heavy demands on scarce tax dollars to finance health care.

But the system has gaps, with perhaps as much as 15 percent of the employed and unemployed population being without health insurance coverage. And as you know, much of the lack of coverage among those who are employed arises in the small business sector and in certain specific industries such as retail and construction.

We share with you the concern over the uninsured, and we want to work with this Committee to find ways to deal with the problem without at the same time so increasing labor costs that jobs are lost.

We perceive that one of the major problems that faces employers who would like to provide coverage is the jungle of State benefit mandates that now exist—over 640 of them. And now, with COBRA and a variety of pending bills, the Federal Government seems to be starting down the track of mandates of its own.

These mandates add a level of expense that small businesses in particular find it difficult to absorb. At the very least, Mr. Chairman, we would urge your support for a measure such as Senate Resolution 218, introduced by Senators Quayle and Bumpers, that would require an assessment of costs and benefits of any mandated benefits proposal. We note the presence of a similar provision in S. 1265.

As this Committee knows, mandates are not a free lunch. No one should believe that social problems can be simply and easily solved by requiring employers to pay the tab. The heart of the problem is that health benefit mandates add to labor costs, and if those cost increments are large enough, jobs will be lost or new job creation imperiled.

We recognize, Mr. Chairman, that you have tried to deal with this problem by limiting the cost of this proposal to about $1,200 per year per employee. Even that, however, is a very large labor cost increment for many companies and especially for those who do not now provide coverage.

Moreover, it has to be said, that companies of all sizes fear that this will only be the beginning, with a moral certainty that the Federal minimum standard will be constantly escalated over time. Indeed, Section 402 of the bill seems to invite such escalation, at least within the confines of Medicaid-covered services.

We urge you not to start down the road to more mandates, but instead to adopt an aggressive approach of removing obstacles and creating incentives for the expansion of employer-provided health insurance coverage. We specifically suggest four things. First, that tax incentives be provided—tax deductions or credits—to nonincorporated businesses that provide coverage for the owner and employees.

Secondly, preemption of benefit mandates, possibly through a modification to ERISA whereby State-mandated benefit laws would be set aside to allow carriers to market less costly packages than they are now compelled to offer and which packages might be more affordable to many companies.

Another possible way to make preemption of mandated benefits a reality would be to establish at the Federal level a minimum actuarial value which an insured employer plan would have to meet in order to be free of State and Federal mandates. Employers not now offering health insurance would not be compelled to do so—but if they did and their coverage met the minimum dollar standard, all mandates would be preempted.

By focusing on a specific dollar amount, we feel more restraint would be built into the system than would be the case with a specific schedule of benefits whose costs are escalating and which can be constantly enlarged to include special interest provisions.

Third, another useful approach would be to broaden the incentives available to multiple-employer trusts and other pooled arrangements such as Taft-Hartley type arrangements to help small firms, especially, to obtain coverage at competitive rates.

And finally, Mr. Chairman, we would join others who have spoken today in calling for an overhaul of the Federal Medicaid Program which, as currently structured, allows many people to fall through the cracks due to different State eligibility tests and benefit levels. We would join in considering the possibility of an income-related buy-in to the Medicaid Program which people with some income or resources might use.

In conclusion, the U.S. Chamber does oppose the approach taken by S. 1265, but stands ready to work with this Committee to fashion a proposal that deals with the problem of gaps in our public/private health insurance system in a manner which is consistent with our mutual goal of sustaining a strong job-creating economy.

Thank you.

Senator **Weicker**. Thank you.

[The prepared statement of Mr. Patricelli and responses to questions submitted by Senator Kennedy follow:]

STATEMENT
on
THE "MINIMUM HEALTH BENEFITS FOR
ALL WORKERS ACT OF 1987" (S. 1265)
before the
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
for the
U.S. CHAMBER OF COMMERCE
by
Robert E. Patricelli
June 24, 1987

Mr. Chairman and members of the committee, my name is Robert E. Patricelli. I am President of ValueCare, Inc., a managed health care company, headquartered in Connecticut. In the past, I have served as head of CIGNA Corporation's health care companies and as Deputy Under Secretary of the U.S. Department of Health, Education, and Welfare from 1970-1971. Presently, I am Chairman of the U.S. Chamber of Commerce's Health Care Council. I am pleased to appear here today on behalf of the Chamber to discuss mandatory employer-provided health coverage and, specifically, the "Minimum Health Benefits for All Workers Act of 1987" (S. 1265). Accompanying me is James A. Klein, Manager, Pension and Employee Benefits for the Chamber.

In brief, the Chamber supports the present system of voluntary, nondiscriminatory, private-sector employee health care benefits plans, which can vary in accordance with the needs of employers and employees. We oppose federal or state government requirements mandating plan design or financing, whether applicable to insured or self-insured plans, because they limit flexibility and raise costs.

The Success of the Voluntary Health Care Financing System

American businesses provide health care coverage to 132 million people, 84 percent of the total private health care coverage in the nation. In 1985, the total health care expenditures of American businesses was $105 billion. That amount does not include the additional portion of public health expenditures that businesses, as taxpayers, helped to finance. This privately-financed health benefits system has permitted American health care to become the best in the world--driven by pluralistic and competitive forces rather than being constrained by the regulation and bureaucracy of national health insurance.

In recent years, there has been increased attention paid to the real problem faced by millions of Americans who lack health care coverage under both the private and publicly-financed systems. The 1986 National Access Survey funded by the Robert Wood Johnson Foundation and conducted by the University of California at Los Angeles found that 9% of respondents -- equivalent to 22 million Americans -- described themselves as uninsured. The Employee Benefit Research Institute reports that approximately 35 million Americans or about 14.5 percent of the population, are without health care coverage, of which perhaps 17 million are people who hold jobs and several million more are the dependents of workers. Whatever the precise number, the problem is substantial and is especially prevalent within the small business sector. A U.S. Small Business Administration analysis of the Bureau of the Census' Survey of Income and Program Participation data indicated that in 1984 48 percent of all uninsured workers were employed by firms with fewer than 25 employees. Including business owners without coverage raises that figure to almost 60 percent of the uninsured.

The Chamber shares this growing national concern over the uninsured and is committed to finding ways to extend private, voluntary coverage without increasing labor costs so that jobs are lost.

Clearly, the issue is not whether the Congress should act to close the gap in health care coverage, but rather how it should best proceed. We recognize the problem of the uninsured and we want to work with you and this Committee on appropriate ways to address it. In our testimony today, we would like to explain some of the current obstacles to broader coverage, describe why we believe the approach set forth in S. 1265 presents a number of problems to be avoided, and suggest a number of viable alternatives to help solve this serious problem.

The Growth of State-Mandated Benefits

Decades of legislation and case law have clearly established that insurance is regulated at the state, not federal, level. Historically, various groups have advocated minimum requirements for benefit levels, elements of coverage, or rules for reimbursement for particular categories of health care providers.

Under this pressure, all states have enacted some mandated health benefit provisions. Typically, these mandates include extensions of eligibility for coverage to various classes of beneficiaries, requirements for health plans to cover treatment for alcoholism, drug abuse, or mental problems, or reimbursement for treatment by particular health professionals. These state mandates now number well over 600. A chart listing some of the various state-mandated benefits is shown in Appendix A.

The proliferation of state-mandated laws undoubtedly has raised health care costs for businesses. Indeed, state-mandated benefits have encouraged many companies to self-insure in order to gain the protection of the Employee Retirement Income Security Act of 1974 (ERISA) against these mandated costs. Regrettably, small employers, which are not able to assume the risks inherent in self-insuring, face higher health care expenses in providing coverage through traditional insurance products. This exacerbates the problems smaller companies face in providing coverage to their employees.

The excessive burdens imposed by mandated benefits have led at least five states, Arizona, Nebraska, Oregon, Pennsylvania, and Washington, to adopt benefit evaluation mechanisms to assess the cost/benefit trade-offs of state-mandated health benefits. The Chamber repeatedly has called for similar assessments at the federal level, and we are pleased that Senators Quayle and Bumpers have introduced such a measure, S. Res. 218, which now is pending before this committee. The advantage of a measure like S. Res. 218 is that it does not prejudge the merits of any particular mandated benefit proposal, but merely directs Congress to assess the advantages and disadvantages of such an approach. The Chamber heartily endorses the passage of S. Res. 218.

The Growth of Federally-Mandated Benefits

Until very recently, the trend toward mandated health benefits remained largely a state law phenomenon. For decades, the only benefits that employers were required by federal law to provide were Social Security, unemployment insurance, and workers' compensation. Indeed, the philosophy of ERISA was to preempt state mandates, at least for self-insured plans, and to avoid erecting federal requirements in their place.

That philosophy began to change with the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which contained provisions requiring employers to continue to make available health care plans to various categories of former employees and their family members for periods ranging from 18 to 36 months. Those "continuation of coverage" provisions were attached to the reconciliation measure with virtually no Congressional discussion.

Although the continuation of coverage under COBRA is made available at the beneficiary's own expense, simply complying with COBRA is an administrative burden for many companies. Moreover, the likelihood that those individuals who are the most frequent users of health care coverage will be the most likely to continue that coverage--with the commensurate increase in insurance premiums due to the adverse selection--belies the claim that COBRA involves no cost to employers. The fact is COBRA and other federal "cost-shifting" to business have been powerful incentives for companies to discontinue or reduce health care or other employee benefits.

This regrettable trend of piecemeal mandates is now seen in H.R. 2300, the "Catastrophic Illness Expense Protection Amendments of 1987" which would mandate certain levels of catastrophic coverage, and S. 968, the "Child Health Incentives Reform Program," which would require first dollar coverage for pediatric health care. An effort to attach one or both bills to the budget reconciliation measure this year is considered likely. This is indeed unfortunate, since using the budget process does not permit the Congress to thoughtfully consider the full implications of these costly mandates.

S. 1265 follows this new trend of federal mandates but it goes beyond the earlier measures by establishing a massive new federally-regulated health care system financed primarily by employers.

S. 1265

Mr. Chairman, you obviously have devoted extensive thought and resources to the development of S. 1265. We note the bill's provisions for certain cost-sharing with employees and allowing "actuarially equivalent" health benefit plans. These provisions inject a certain degree of flexibility in an otherwise inflexible mandated system. Unfortunately, the bill does not provide relief from the single greatest obstacle which has obstructed the further spread of employer-sponsored coverage in the small business sector and in certain industries (e.g. retail and construction) — namely, that comprehensive health coverage is extremely costly and can represent an unacceptable increase in labor costs.

The benefits package that the bill requires is still out of reach for most of the businesses that today do not offer coverage to their employees. The estimate of the actuarial firm you consulted, Mr. Chairman, is that the average annual expense per employee in 1988 under the terms of S. 1265 would be $1,186. That is a sizeable and, in many instances, unaffordable expense for the very companies which we would all like to see offer coverage. Moreover, while you have made some effort to restrain the cost of the mandated benefit package in this bill, businesses of all sizes fear later piecemeal escalation. Indeed, even now, it is unclear whether COBRA and S. 968, if enacted, would add expense over and above that specified in this bill.

Second, we doubt that the bill's plan for qualifying regional insurers will ultimately produce premium savings. With no more than five insurers selected (under restrictive conditions) to market health insurance to a captive group of all firms with fewer than 25 employees, the competitive, pluralistic insurance provider options that have flourished in recent years will be undermined. Simply put, many smaller insurance companies will likely be crowded out of the market. It is hard to envision how creation of regional oligopolies will lower costs.

Returning to the major issue, it is an inescapable fact that added expenses for health care costs will mean a loss of jobs. The only difference of opinion can be the degree of job loss. In 1981, the federal Minimum Wage Study Commission estimated that a basic rule of thumb for job loss is one percent for every 10 percent increase in labor costs. This same estimate of job loss due to S. 1265 was cited by Karen Davis of Johns Hopkins University at the May 19, 1987 hearing of this committee--and she was testifying in favor of the bill.

One of the most significant statistics regarding the uninsured is that, as reported by the Employee Benefit Research Institute, nearly two-thirds of the group is at an income level below 200 percent of the national poverty level. This clearly indicates that many of those working without coverage are among the lowest income earners. For their employers, the 40 to 50 cents per hour increased cost of labor caused by S. 1265 would represent a relatively high percent increase in salary, and a correspondingly greater level of job loss. We note that this effect would be exacerbated by an increase in the minimum wage level, which simultaneously is being considered by the Congress.

Even where direct job loss will not result from increased health costs, lower wages and other benefits, diminished investment, and stifled job creation will result. Small firms have created most of the new jobs in our economy in recent years--a trend that would be thwarted, in part, by a costly new mandate. As Princeton professor Uwe E. Reinhardt has said, a benefit mandate is "a tax on employment and entrepreneurship."

It is important to note that although the adverse effects of mandates would fall disproportionately on smaller firms, concern with the mandated approach is not confined to this sector of the business community. Large companies, which have made the greatest strides in health care cost containment initiatives, stand to lose a great deal under a scenario whereby the federal government dictates the design of benefit plans and businesses must pay for the level of coverage required. Even though the coverage prescribed by S. 1265 may be comparable, in many instances, to what many major employers now provide for their workers, many of these firms have little confidence that Congress will refrain from its tendency to shift health costs to business and mandate further costly benefits. Recent cost-shifting to business within budget reconciliation bills and the explosive number of mandates at the state level lend credence to this well-justified concern. Moreover, large companies rely upon small companies as subcontractors and suppliers. Increased costs for the smaller firms translates into increased costs for the large businesses that are more likely competing directly in the international marketplace.

The Chamber has established and is coordinating the "Coalition on Mandated Benefits," which includes several hundred trade and professional associations, chambers of commerce, and businesses, large and small, that are concerned about mandated health benefits. A number of the nation's largest firms—Lockheed, ARMCO, Bethlehem Steel, Sherwin-Williams, Marriott, Safeway, Piedmont Aviation, FMC Corporation, CBS Inc., and many others--have joined our Coalition to resist benefit mandates.

These varied concerns with mandated benefits, as outlined above, underscore the need to pursue a flexible approach to expanded employer-provided coverage so that more cost-effective ways of providing health coverage to those who currently lack it can be developed. It is to that challenge that we now wish to turn our attention.

Alternative Methods to Expand Health Care Coverage

The Chamber's Board of Directors recently adopted policy on expanding health care coverage (see Appendix B). As you will note, this policy statement recognizes that there are a number of reasons people lack health coverage. Some are employed but their employers do not offer coverage, some are unemployed and thus have no employer-based coverage, and some have medical conditions that prevent them from obtaining coverage through conventional means. Accordingly, the recommended methods for assisting these groups also must differ and be flexible.

Focusing on the individuals who are employed but lack coverage (the group that the business community is best able to assist), the Chamber is developing legislative proposals to implement our policy position that we believe will present viable alternatives to the inflexible mandate of S. 1265. Moreover, our alternatives should minimize the job dislocation problems of S. 1265, because they stress incentives to make health care coverage more affordable to small businesses. These alternatives echo many of the options that the sponsors of S. 1265 and other health policy experts have suggested.

Briefly, our approach suggests that federal legislation be enacted which would provide incentives and remove obstacles for the provision of employer-sponsored health insurance. We feel strongly that such an approach must be fully implemented before the Congress even considers any system of mandated coverage. Our proposal, which is still under development, stresses the following elements.

Tax Incentives

Virtually all commentators on small business health care coverage have called for an expansion of the tax deduction for non-incorporated businesses that provide coverage for the owner and employees. It has been only since the beginning of this year that such business owners have received any deduction -- 25 percent. We note that you, Mr. Chairman, have called for an 80 percent deduction and we applaud that proposal. We believe that the deduction for non-incorporated firms should be 100 percent, as you proposed last year in S. 2402 "The Access to Health Care Act." Alternatively, it might be possible to offer a tax credit, which would be more useful than a deduction, to small firms with slim profits. A tax incentive approach would expand coverage among non-incorporated, sole proprietorships--where it is most lacking.

We readily acknowledge that any expansion of this deduction will cost the U.S. Treasury revenue. Likewise, S. 1265 will exacerbate the federal budget deficit because businesses providing coverage will take a deduction for their expenses. Since controlling federal budget deficits is a vital concern, we reemphasize the critical importance of passing the previously-mentioned S. Res. 218, or some similar economic impact mechanism, so that the costs of both S. 1265 and our suggested alternatives can be assessed.

Preemption of State-Mandated Benefits

As the chart in Appendix A demonstrates, every state has adopted some health mandates. These numerous state-mandated benefits, plus the growing number of federal mandates, make the provision of health insurance policies much more expensive and have been a significant factor in many companies electing to self-insure. Regrettably, self-insurance is not a viable option for many small firms which simply do not possess the financial resources to assume the risk inherent in self-insuring the health coverage for their employees.

A possible alternative would involve a modification to ERISA, to preempt the state-mandated benefit laws, and thereby allow insurance carriers to market a less costly insurance package than they are now compelled to offer. In essence, this would allow insured firms to enjoy the same flexibility as self-insured firms. A less costly benefits package, then, could be within the financial grasp of many companies that presently cannot afford more costly comprehensive coverage.

Another possible way to make preemption of mandated benefits a reality, would be to establish at the federal level a minimum actuarial value which an insured employer plan would have to meet in order to be free of state and federal mandates. Employers not now offering health insurance would not be compelled to do so, but if they did and their coverage met the minimum dollar standard, all mandates would be preempted. This would still leave with the states the fundamental regulation of insurance in terms of financial soundness and consumer service.

Such a minimum actuarial value should be set at a low enough level to encourage the voluntary adoption of new plans. By focusing on a specific dollar amount, we feel more restraint would be built into the system than would be the case with a specific schedule of benefits whose costs are escalating and which can be constantly enlarged to include special interest provisions.

We note that S. 1265 also amends ERISA to preempt state mandated benefits and then imposes certain federal standards. We recognize that there are some who do not wish to preempt state mandates without substituting a new set of federal prescriptions. However, our intention is to avoid specific benefit mandates at either the state or federal level, feeling that benefit plan structure is best left to determination between the employer and employee.

Multiple Employer Arrangements

One of the areas where much more work needs to be developed concerns the use of multiple employer trusts (METs) and other similar arrangements to help small firms, especially, obtain health coverage at competitive rates. The basic premise of a MET or similar entity is to allow many businesses to pool resources, and thereby either self-insure (and obtain corresponding cost savings) or use their greater numbers to obtain coverage from an insurance carrier at a lower rate. These efforts have been very successful among many trade associations and state and local chambers of commerce. We are pleased that S. 1265 recognizes the value of these pooled arrangements. We do not believe that these small business arrangements need to operate in concert with regional insurers, as is contemplated by Section 324 of S. 1265, but we welcome the opportunity to work with the Congress to find the best way to encourage these small business arrangements.

Medicaid

The Medicaid system is a complex amalgam of federal and state responsibilities and regulations. This Committee heard ample testimony at its May 19, 1987, hearing that the system as currently structured forecloses health coverage to many people of very modest means. Medicaid restructuring, perhaps to allow an income-related "buy-in" to the program, may be one means of permitting access to health care for both working and non-working persons. Obviously, important issues of benefit levels, federal/state authority, and the fiscal integrity of the system must be weighed. We must ensure that a Medicaid buy-in supplements, rather than supplants, the private health care coverage system.

Health care coverage in this nation is a private and public-sector partnership. That joint responsibility should be preserved so that the broadest coverage possible, rendered in the most efficient method, is achieved.

Conclusion

We recognize that some members of Congress want to leap to national mandates to deal with current gaps in private health insurance coverage. We feel that would be shortsighted and would create economic dislocation that would more than offset gains in terms of access to health care. We urge an approach which creates incentives, eliminates obstacles, and corrects the gaps in the Medicaid patchwork as a logical and effective first step. Encouraging greater flexibility in the types of coverage that can be offered--rather than imposing restrictions on such coverage--can expand employer-sponsored coverage without the corresponding financial burdens to business and job loss for the very people whose health care protection we seek to achieve.

The Chamber stands ready to assist the Committee in addressing these important issues. Thank you.

APPENDIX A

State-Mandated Health Benefits

	Alcoholism	Allied Practitioners	Drug Abuse	Handicapped Children	Home Health	Maternity	Mental Illness	Newborns	Surgical Centers	Miscellaneous	Nursing Home	Hospice	Continuous Conversion	HMOs	PPOs	Risk Pool-Catastrophic	State Program-Catastrophic	Total
Alabama	●	●					●	●		●			●					6
Alaska		●						●					●				●	4
Arizona	●	●	●	●	●	●	●	●	●	●	●							11
Arkansas		●		●		●	●	●	●	●			●					8
California	●	●		●	●	●	●	●		●			●		●			10
Colorado	●	●			●	●	●	●					●					7
Connecticut	●	●	●	●	●	●	●	●		●	●	●		●		●	●	14
Delaware		●						●										2
District of Columbia		●						●										2
Florida	●	●	●	●		●	●	●	●	●			●		●	●		12
Georgia		●		●		●	●	●	●	●			●					8
Hawaii		●		●				●										3
Idaho		●		●		●		●		●	●		●	●			●	9
Illinois	●	●		●		●	●	●		●			●					8
Indiana		●		●				●		●					●			5
Iowa		●				●		●		●			●					5
Kansas	●	●	●			●	●	●		●			●					8
Kentucky	●	●		●	●	●		●	●				●					8
Louisiana	●	●	●	●			●	●	●	●			●		●			10
Maine	●	●	●		●	●	●	●					●				●	9
Maryland	●	●	●	●	●	●	●	●		●		●	●	●				12
Massachusetts	●	●		●		●	●	●		●			●					8
Michigan	●	●	●	●		●		●		●				●	●			9
Minnesota	●	●	●	●		●	●	●	●	●			●	●	●	●	●	14
Mississippi	●	●		●				●		●								5
Missouri	●	●	●	●		●	●	●	●	●			●					10
Montana	●	●	●	●	●		●	●		●			●					9
Nebraska	●	●		●		●		●		●			●		●			8
Nevada	●	●	●	●	●	●		●	●	●		●	●					11
New Hampshire		●		●		●	●	●		●			●					7
New Jersey	●	●		●	●	●		●		●			●	●				9
New Mexico	●	●		●	●			●		●			●					7
New York	●	●		●	●	●	●	●	●	●			●	●			●	12
North Carolina	●	●	●	●		●		●		●			●					8
North Dakota	●	●	●	●		●	●	●		●			●			●		10
Ohio	●	●		●		●	●	●		●			●					8
Oklahoma		●		●		●		●	●	●			●					7
Oregon	●	●	●			●	●	●		●			●					8
Pennsylvania		●		●		●		●					●					5
Rhode Island	●	●		●	●	●		●		●			●	●		●	●	11
South Carolina		●		●				●		●			●					5
South Dakota	●	●		●				●		●			●				●	7
Tennessee	●	●	●	●		●	●	●		●			●					9
Texas	●	●	●	●		●	●	●		●			●					9
Utah	●	●		●		●		●	●	●			●		●			9
Vermont	●			●	●	●	●	●		●			●					8
Virginia	●	●	●	●		●	●	●		●			●		●			10
Washington	●	●		●	●	●	●	●		●			●	●				10
West Virginia	●	●		●	●	●	●	●		●		●	●	●	●			12
Wisconsin	●	●	●	●	●	●	●	●		●	●		●		●	●		13
Wyoming		●		●				●		●			●					5
Total	37	50	19	42	17	38	29	51	12	43	3	4	44	10	11	6	8	na

Source: Matrix prepared by Coalition Clearinghouse from data obtained from the Health Insurance Association of America and the National Conference of State Legislatures

APPENDIX B

STATEMENT ON EXPANDING HEALTH CARE COVERAGE

The vast majority of Americans have health coverage provided through either private or public programs or a combination of both. Employers are a vital component of the health care system -- providing 84% of total private health care coverage to 132 million people under age 65, through voluntary employer-sponsored plans. Employers also pay a major share of the cost of public programs. Notwithstanding the wide availability of health care coverage, many Americans (estimated up to 34.8 million) are not included under established public or private health plans.

Ensuring adequate health care coverage for all who seek it is an important societal goal. Accordingly, it is important for all elements of our society -- not only the employer community -- to commit the resources necessary to achieve that goal.

In order to expand health care coverage, certain realities must be recognized:

(a) additional financial resources, in the form of direct government funding, tax expenditures, and private sector funding is necessary.

(b) to help assure access to adequate health care for those in the labor force, existing employer incentives to provide health insurance to employees and their dependents should not be jeopardized; there must be additional incentives and the removal of barriers (such as state mandated benefits, continuation of health care requirements and burdensome non-discrimination rules), for individuals and small employers to obtain coverage.

(c) mandating that businesses offer and/or pay for expanded coverage raises serious issues regarding, among others, the affordability of such coverage to business and the impact on the competitiveness of American business in a global economy. It also is at variance with the traditional voluntary private sector employee benefits system. Such issues require thorough examination by those considering mandates as a method for expanding health care coverage.

In addressing the problem of how to expand health care coverage, it is essential to recognize that individuals lack coverage for a variety of reasons. Some people are unemployed and do not have the means to obtain coverage. Some people are employed, but work for employers that do not offer health coverage as an employee benefit. Some persons are unable to obtain insurance in the private marketplace due to pre-existing medical conditions that make them ineligible for insurance. Finally, some individuals (primarily younger and healthier persons) choose not to have health care coverage.

The variety of factors responsible for the lack of universal coverage requires a variety of specific responses.

(over)

Options that deserve serious consideration include:

For individuals denied coverage for health reasons

- narrowly targetted programs to provide core medical benefits to persons who are unable to obtain insurance coverage due to their medical condition. The subsidy for such programs should be spread across the broadest possible base -- not just paid for by employers or other purchasers of health care. The establishment of the programs must be contingent upon specific cost-containment requirements.

- the public debate over coverage for individuals ineligible for insurance due to health reasons has heretofore been focused on the establishment of subsidized risk pools; other alternatives such as an income-related Medicaid buy-in program should be explored as well as other programs already in place.

For the uninsured in the labor force

- expanded tax and other incentives and the removal of barriers for employers to provide coverage to employees; such incentives are especially important to encourage small businesses to offer employment-based coverage.

- encouragement of opportunities for businesses to obtain less expensive and less administratively burdensome health coverage for employees such as participation in multiple employer trusts (METs) and health care plans offered by trade and professional associations and chambers of commerce.

- state technical assistance programs to faciliate affordable health insurance for individuals and small businesses; financed as broadly-based as possible.

For the uninsured out of the labor force

- an income-related Medicaid buy-in program.

- expanded coverage through a variety of public and private programs.

Policy-makers should also encourage initiatives for individual health care and long-term coverage such as (a) income-related tax deductions and credits for health insurance premiums for uninsured individuals who are not offered employment-based coverage, and (b) tax incentives for the establishment of individual medical accounts that would permit increased personal savings for health care and the purchase of health care insurance.

Adopted by U.S. Chamber
of Commerce — March 1987

July 21, 1987

Senator Edward M. Kennedy, Chairman
Committee on Labor and Human Resources
527 Hart Senate Office Building
Washington, DC 20510

Dear Senator Kennedy:

I am pleased, on behalf of the United States Chamber of Commerce, to enclose responses to the additional questions you have raised regarding my testimony on S. 1265.

Please do not hesitate to contact me or the Chamber if we may be of further assistance.

Sincerely,

Robert E. Patricelli
President

smg

Enc.

cc: Mr. James A. Klein, Manager, Pension and Employee Benefits
United States Chamber of Commerce

QUESTIONS FOR ROBERT PATRICELLI

1. An earlier witness testified that an ad-hoc committee of the Chamber was studying our legislation and had not yet taken a position on it. I take it then, that, you are testifying based on pre-existing Chamber policy. Is this correct?

2. I was gratified by your testimony that the "issue is not whether Congress should act to close the gap in health care coverage, but rather how it should best proceed." Do you favor massive subsidies to the private sector as a way of closing this gap--in addition to the tax subsidies that already exist?

3. You said you favored alternative measures, but you only mentioned three: improving the tax treatment of the self-employed, which I strongly support, encouraging the growth of multi-employer trusts, and eliminating State mandated benefit laws. Do you really believe that these limited measures are going to extend health insurance coverage to 24 million workers and their dependents? The fact is that 20 per cent of all the uninsured workers are employed by firms of more that 1,000 employees--and those three recommendations will not affect these firms in the least--isn't that true?

4. There are a number of laws that are very similar to our legislation in that they require employers to provide or finance benefits and they presumably raise labor costs. Let me list them. They include Social Security, Medicare, unemployment compensation, workman's compensation, and the minimum wage. Do you think our society is better or worse off for having those protections in place?

RESPONSES TO QUESTIONS FROM
SENATOR EDWARD M. KENNEDY, CHAIRMAN,
COMMITTEE ON LABOR AND HUMAN RESOURCES

1. We are testifying based upon policy which was adopted by the Chamber's Board of Directors in March 1987 and reaffirmed by the Board at its June 10, 1987 meeting. A special Task Force on Gaps in Coverage, to which you referred in your question, had developed a policy statement to address the problem of those without health insurance, based upon its inquiry into the subject and a review of the draft outline of your legislation. That task force's parent body, the Chamber's Health Care Council, revised and adopted that policy statement, and the Chamber Board approved it in March 1987. The policy statement appears as Appendix B to our formally-submitted written testimony.

   I want to underscore and clarify the statement of the earlier witness to which you referred. The efforts of the Chamber's Task Force on Gaps in Coverage are not complete in that it will continue to work on addressing the needs of those without health coverage and to develop viable alternatives to mandates. However, the work of the task force is complete regarding its restatement of the Chamber's concern about mandated health benefits and its description of the parameters of the uninsured health care problem.

2. No. We do not propose massive subsidies. In fact, one of the problems with your bill, S. 1265, is how the U.S. Treasury could afford the major new tax expenditures the bill would generate. The Institute for Research on the Economics of Taxation, for example, estimates the tax expenditure impact of S. 1265 to be $35 billion in 1988 alone.

   The revenue loss from the expanded tax deduction for non-incorporated businesses--which we do support--would be about $1 billion according to Senator Dale Bumpers, who has introduced a bill to expand that deduction from 25% to 100%. The other alternatives we suggest--pre-emption of federal and state mandates, expansion of multiple employer trusts, and Medicaid buy-ins--involve few, if any, subsidies to businesses.

3. In addition to the alternatives you cite, we also have suggested a pre-emption of specific federal benefit mandates and a Medicaid buy-in arrangement. Thus, we have put forward four suggested alternatives. At least one of those--pre-emption of state and federal mandates--we feel would be attractive to firms with more than 1,000 employees. At this time, it is impossible to know precisely how many additional people would obtain health coverage with the adoption of our proposals. By the same token, we are certain that the sponsors of S. 1265 do not know how many employees might be laid off or not hired initially--and, therefore, not obtain employer-provided health coverage--if S. 1265 became law.

   Since the high cost of health insurance is the main obstacle to expanding coverage, we believe that our alternatives at least should be tried before Congress considers a mandatory approach. Once the number of uninsured is reduced, we might find that other means will more efficiently address the needs of those who remain uninsured.

4. The Chamber supports viable Social Security, Medicare, unemployment insurance, and workers' compensation programs. As for minimum wage, the Chamber has testified extensively on this issue in recent weeks, and I would direct your attention to the statement filed with this committee on June 10, 1987, for the most complete analsyis of our position.

   Clearly, American workers are better off for the existence of programs which protect them agains the vicissitudes of old age, loss of employment, or workplace injury. The challenge to Congress and the private sector is to craft these programs in such a way as to ensure protection for employees and retirees without unduly burdening business so that employers are induced to cut back on wages or other benefits or to reduce overall levels of employment. We do oppose putting mandated programs in place before approaches involving incentives and removal of regulatory barriers have been fully explored.

Senator Weicker. Mr. Rudd.

Mr. Rudd. Mr. Chairman and Members of the Committee, my name is Gerald Rudd. I am Senior Vice President for Human Resources for Albertson's Inc., in Boise, Idaho.

Albertson's operates 457 supermarkets in 17 States. I am also Chairman of the Food Marketing Institute's Benefits Council, and I am here today on behalf of the Food Marketing Institute.

We very much appreciate the opportunity to express our views on Senate bill 1265, the Minimum Health Benefits for All Workers Act.

FMI is a nonprofit association, conducting programs in research, education and public affairs on behalf of its 1,500 members—food retailers and wholesalers and their customers in the United States and overseas.

FMI's domestic members operate more than 17,000 retail food stores with a combined annual sales volume of $180 billion—half of all grocery sales in the United States. More than three-fourths of FMI's membership is composed of independent supermarket operators or small regional firms, and half are one-store operators.

In other words, Mr. Chairman, we are the small businessmen that your Committee has expressed so much concern for.

Food retailers and wholesalers employ over 3 million Americans. This represents one of the largest segments of the work force and one of the fastest growing. Since 1980, our industry has created over 600,000 new jobs.

FMI and its members respect the intentions of the sponsors of this legislation. Indeed, we share many of the premises behind it. We agree that the cost of health care in this country is unacceptably high.

We agree it is simply unacceptable that some Americans today are denied access to quality health care because they are unable to pay for it or because they are not covered by health insurance.

But we disagree strongly with this proposed legislation as a solution to the health care crisis in this country. Mandated employer-paid health insurance for all workers and their dependents will simply lead to even higher health care costs; higher consumer prices generally; fewer employment opportunities for those who need jobs the most, and reduced benefits to all employees.

Now, we can understand why those who are concerned about providing adequate health care to all Americans would turn to the employer community for that coverage. After all, employers already provide coverage for over 130 million Americans. After all, we already pay over $105 billion annually for health coverage for their employees and dependents, not including taxes paid toward public health expenditures.

So, wouldn't an easy answer be to simply mandate that employers pay for the health care of all Americans and their dependents? Wouldn't that be the cheapest solution to the problem?

Mr. Chairman, the answer is "no" and "no". Simple solutions are not necessarily the best solutions. This back door approach to national health insurance may not entail a direct expenditure of Federal funds. But if these huge costs are imposed on the private sector, they do not just disappear. They simply go underground and become hidden in the overall cost structure of the employer's business and in the cost of the products and services they produce. In addition they will generate other significant societal and economic costs as well.

Now, Mr. Chairman, much concern has been expressed about part-time employees in this hearing. Let me briefly explain that approximately 66 percent of our workforce in the retail industry are part-time employees. So we consider ourselves experts on the employment of part-time people.

The effect of this legislation would simply be to drive the cost of part-time employees up to the extent that it would make them economically unattractive employees. Remember that the hourly cost of this legislation would be twice as high for a 20-hour employee as it would be for a 40-hour employee, and they would simply be driven out of the employment market.

I would also call to your attention that 90 percent of these employees, the part-time employees in the retail industry, are under 24 years of age, and it would very severely depress the job market for youngsters in that age category.

One final point, Mr. Chairman. This legislation is not a modest proposal or a simple extension of benefits to a few needy Americans. It is a fundamental restructuring of a relationship among the Federal Government, business and the American workforce. And before we legislate such a drastic change, there should be a full and thorough debate on this issue.

It has now been one month since this legislation was unveiled, and this is billed as the only hearing before committee consideration.

Our members are very, very concerned about this kind of precipitous legislative action. We are still in shell-shock over the legislative sleight-of-hand that resulted in the COBRA health care provision last year. We urge this Committee and others with appropriate jurisdiction to give this important the comprehensive review that it deserves.

We urge you to look at all the possible alternatives for providing quality health care to all Americans. And we urge you to consider all the consequences of mandated benefits—on small business, on employment, on international competition, on consumers, and on the employees this bill is designed to help.

FMI pledges to work with you to achieve that goal, Mr. Chairman. Thank you very much.

Senator WEICKER. Thank you very much.

[The prepared statement of Mr. Rudd follows:]

STATEMENT

of the

FOOD MARKETING INSTITUTE

on

S. 1265

THE MINIMUM HEALTH BENEFITS

FOR ALL WORKERS ACT

Before the

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

June 24, 1987

My name is Gerald R. Rudd. I am Senior Vice President for Human Resources of Albertson's, Inc., in Boise, Idaho. Albertson's operates 457 supermarkets in 17 states. I am Chairman of the Food Marketing Institute's Benefits Council and I am here today on behalf of the Food Marketing Institute (FMI). We very much appreciate the opportunity to express our views on S. 1265, the Minimum Health Benefits for All Worker's Act.

FMI is a nonprofit association conducting programs in research, education and public affairs on behalf of its 1,500 members -- food retailers and wholesalers and their customers in the United States and overseas. FMI's domestic member's operate more than 17,000 retail food stores with a combined annual sales volume of $180 billion -- half of all grocery sales in the United States. More than three-fourths of the FMI's membership is composed of independent supermarket operators or small regional firms, and half are one-store operators.

Food retailers and wholesalers employ over three million Americans. This represents one of the largest segments of the workforce and one of the fastest growing. Since 1980 our industry has created over 600,000 new jobs.

FMI and its members respect the intentions of the sponsors of this legislation. Indeed, we share many of the premises behind it.

o We agree that the cost of health care in this country is unacceptably high.

o We agree that it is simply unacceptable that some Americans today are denied access to quality health care because they are unable to pay for it or because they are not covered by health insurance.

o But we disagree -- absolutely and totally disagree -- with this proposed legislation as a solution to the health care cost crises in this country. Mandated employer-paid health insurance for all workers and their dependents will simply lead to:

- Even higher health care costs.

- Higher consumer prices generally.

- Fewer employment opportunities for those who need jobs the most.

- And reduced benefits to all employees.

We can understand why those who are concerned about providing adequate health care to all Americans, would turn to the employer community for that coverage. After all, employers already provide coverage for over 130 million Americans. After all, employers already pay over $105 billion yearly for health coverage for their employees and dependents, not including taxes paid toward public health expenditures. So wouldn't the easy answer be to simply mandate that employers pay for the health care of all Americans and their dependents? Wouldn't that be the cheapest solution to the problem?

Well . . . no, and no. Simple solutions often are not the best solutions. This backdoor approach to national health insurance may not entail a direct expenditure of federal funds. But if these huge costs are imposed on the private sector, they will not disappear. They will only go underground and become hidden in the overall cost structure of the employer's business, and in the cost of the products and services they produce. In addition they will generate other significant societal and economic costs as well.

o In the long run, mandated employer health insurance will jeopardize the successful voluntary employee benefits system, which provides for the health and welfare of the vast majority of Americans today.

o It will contribute to a continuing escalation of health care costs in this country.

o And it won't insure as many Americans as you might think because of the job loss that will result from this legislation.

Voluntary Benefits

Food retailers and wholesalers believe strongly in the voluntary benefits system. They offer a wide variety of benefits to their employees for a variety of reasons. It enables them to attract and retain a productive, dedicated and loyal workforce. The provision of employee benefits has expanded greatly over the years -- increasing from 17% of payroll in 1955 to over 35% in 1986.

My company, Albertson's, is a good example. We provide an elaborate package of health benefits, including medical-surgical coverage, dental, visual and psychiatric care, and disability and life insurance. We do this not because we are required to, but because it is good business. It has enabled us to provide a stable, secure, well-motivated workforce that has fueled both our profitability and our growth. It has strengthened our ability to compete in the job market, just as superior service has strengthened our ability to compete in the market for consumer dollars.

We are not an exception in our industry. FMI has just conducted a comprehensive survey of employee benefits offered to our employees. We believe the results of the survey will prove that our voluntary benefits system is working extraordinarily well. We received responses from companies operating over 10,000 stores and employing over one million Americans. More than half the respondents operate fewer than 10 stores. Attached as an appendix to this statement are some of the preliminary results. A final report will be released next month. But let me run through some highlights:

o Ninety-seven percent offer health benefits to full-time workers on a voluntary basis.

o Over 80 percent include catastrophic coverage in their health insurance.

o Over 70 percent offer short-term disability, 95 percent dental coverage, 70 percent retirement and savings plans.

o Eighty percent offer paid maternity leave.

Our survey showed that most employers in our industry provide relatively generous health care packages. The average plan for hourly workers costs over $1,400 per year per employee. Individual deductibles in 90 percent of the plans are less than $200. Family deductibles in 80 percent of the plans are less than $300. Employers cover all the insurance costs in more than one half of the plans.

One point confirmed by the survey is the diversity of our workforce and the benefits provided them. No two companies offer the same benefits package. This is one of the strengths of the voluntary system. The fact is that no two communities or workforces or workplaces are the same. It should be left to the employer and the individual employees to determine the benefit package most useful to that group of workers. Only in this manner can employers optimize the beneficial effect of health benefit programs to the needs of their employees.

Mandated benefits will mean uniform benefits independent of need. It makes no sense for a three-month, part-time employee -- with no commitment to the company or the industry -- to receive the same benefits as a 20 year, full-time employee, who has made a career commitment to our industry.

Costs

Mr. Chairman, you estimate the cost of this legislation to be $25 billion--$20 billion of that to be paid directly by the employer. We believe those numbers are low. We base that belief on what our survey shows our members are paying now for benefits which do not include all the first-dollar coverages that would be required under the bill.

But for the moment, let's accept your figures. Would you support a new $25 billion federal sales tax to pay for health insurance coverage for the uninsured in this country? Probably not. Because you would correctly argue that a sales tax is a regressive tax that hits those least able to afford it the hardest. Yet, essentially that's what we are talking about here. The $25 billion cost of this program will not disappear because employers pay it. The bulk of it will be reflected in the price of products purchased by consumers. Of course, it will be hidden in those prices, so consumers will not be aware that they are paying for their health care when they purchase their groceries, clothes or automobiles.

Food distribution is a very labor-intensive industry. The U.S. Department of Agriculture estimates that 45 cents of every dollar consumers spend for food goes to labor costs. To the individual grocer, labor is the largest expense after product cost. This legislation, along with many other benefits proposals now moving through Congress, would increase those costs sharply.

We are a "pass through" industry, Mr. Chairman, in which we measure profitability in terms of fractions of 1%. One "cough," one minor change in costs and we lose even that. It is a fact of economic life that much of these costs will be passed along to consumers in the form of higher prices.

Those cost increases will have other effects as well. You can be sure that the increased dollars directed to mandated health care will mean fewer dollars for other benefits, that may be even more valuable to our employees:

o Pensions.

o Vacations.

o Profit sharing.

o Substance-abuse programs.

o Educational opportunities, and all the other benefits we have come to take for granted.

In addition, the increased payments for health care will mean new pressure to reduce wage rates, or at least, to resist further increases.

And finally there will be a job impact. In our industry especially, it will just not be economically feasible to risk hiring those employees on the margin of the workforce, for whom we would incur substantial additional health care costs.

Fairness

The Minimum Health Benefits for All Workers Act asks employers in this country to assume the role of the government in providing for for the basic care of our citizens. We seriously question whether this is good public policy. But as a practical matter, this legislation would be disastrous for the grocery industry and for consumers.

It would require complete health coverage for a part-time, minimum-wage worker on the job for just 30 days. Once that coverage is instituted it must remain in effect, far beyond the term of the employment. Pursuant to the COBRA continuation coverage law enacted last year, that employee would be entitled to continue coverage at his or her own expense for 18 months after employment ends. Qualified dependents could continue coverage for 36 months. In other words, employees could quit their jobs for any reason, after 30 days on the job, and their family would be covered under the employer's plan for another three years!

This is not an especially unrealistic scenario. In the food retailing business, approximately two-thirds of the workforce is part-time. The typical new supermarket today employees well over 100 part-timers. This is the nature of the 7-day-a-week, 24-hour-a-day business environment in which we operate. Our industry has always attracted large numbers of young people, students and others interested in part-time work to supplement their income provided by parents and spouses.

FMI's benefits survey shows that 61 percent of our part-timers are under the age of 21. Ninety percent are under 25. The turnover ratio for those employees exceeds 60%. The administrative burden of keeping track of former employees alone would be overwhelming for employers in the grocery industry. This burden would be especially difficult for smaller independent grocers. Does it make any sense to impose this nightmare for the sake of college-students working their way through school? And who are probably already covered through their parents' health plan?

The actual cost of providing the required coverage could be stupendous. Multiply 100 part-timers by $1,200 a year or more and you can see that cost for a single store; $120,000 buys an awful lot of groceries.

There is no doubt in my mind that the costs of this coverage for part-timers will lead to the elimination of many jobs. Grocers will have to increase automation to hold down costs. I personally believe that these costs, on top of your recently proposed minimum wage increase would, sink a great many of the smaller grocers in our industry. Of course, all the employees out of a work as a result would wind up without health insurance of any kind. You can shear a sheep every year, Mr. Chairman, but you can kill it only once. This could well be the fatal blow to many companies teetering on the edge of failure.

Also, as I have mentioned, there is no doubt in my mind that other benefits valuable to employees would have to be reduced or eliminated. At Albertson's we would have to look at our entire benefits package to see where we could cut costs. And with all these new mandated-benefits costs, we would be far less able to continue to increase wage rates for our productive employees.

Mr. Chairman, I am not an expert on health care. But I do know something about benefits, business and basic economics. I simply do not see how this bill can do anything but further escalate health care costs. All we are doing here is writing a $25 billion blank check to the health care providers. Despite all the recent cost containment measures undertaken by business, health care costs have increased unabated. It is wishful thinking to presume that the increased demand for health care created by this measure will not further that trend.

One final point. This legislation is not a "modest" proposal or "simple" extension of benefits to a few needy Americans. It is a fundamental restructuring of the relationship among the federal government, business and the American workforce. Before we legislate such a drastic change there should be a full and thorough debate on the issue. It now has been one month since the legislation was unveiled and this is billed as the only hearing before committee consideration.

FMI's members consider this kind of precipitous legislative activity to be unacceptable. We still are appalled over the legislative slight of hand that resulted in the COBRA health care provision last year. We urge this committee and others with appropriate jurisdiction to give this important issue the comprehensive review it deserves. We urge you to look at all the possible alternatives for providing quality health care to all Americans. And we urge you to consider all the consequences of mandated benefits -- on small business, on employment, on international competitiveness, on consumers -- and on the employees this bill is to help.

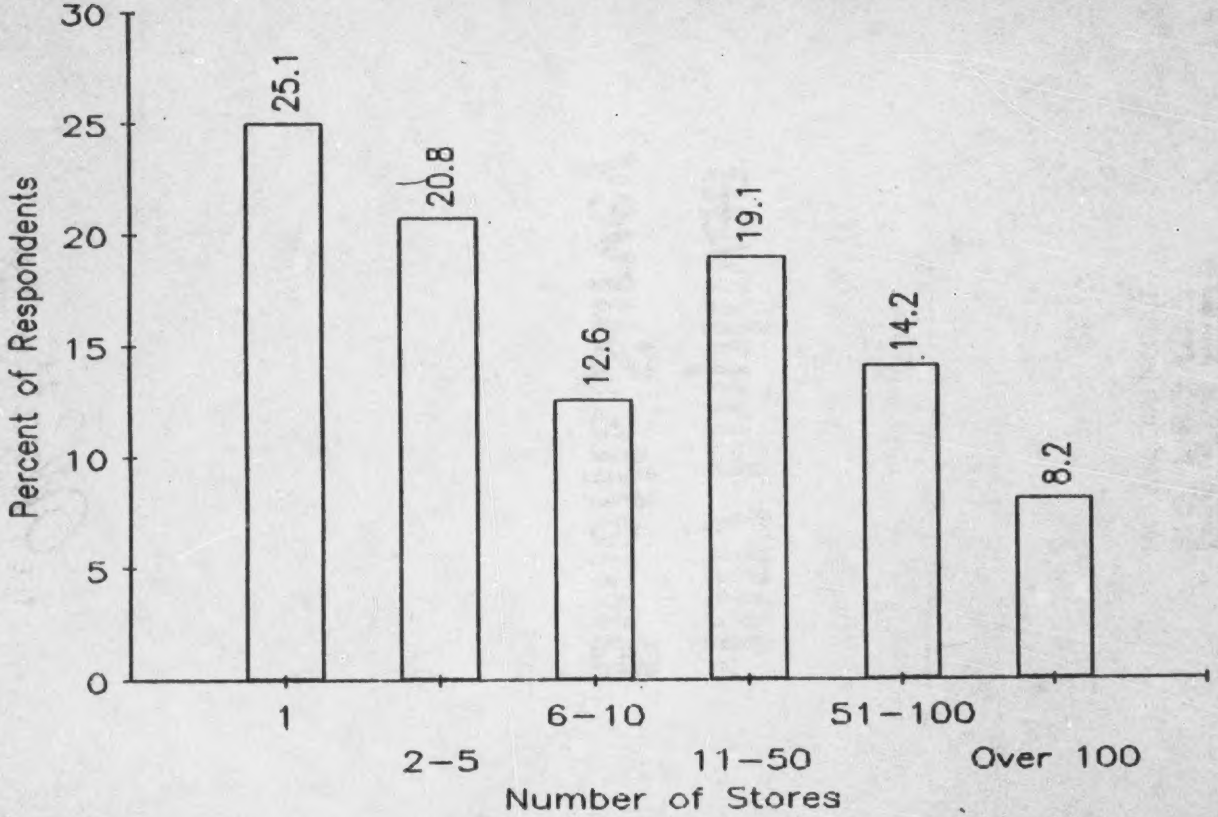
FMI pledges to work with you to achieve that goal. Thank you.

FOOD MARKETING INSTITUTE

1987 Employee Benefits Survey

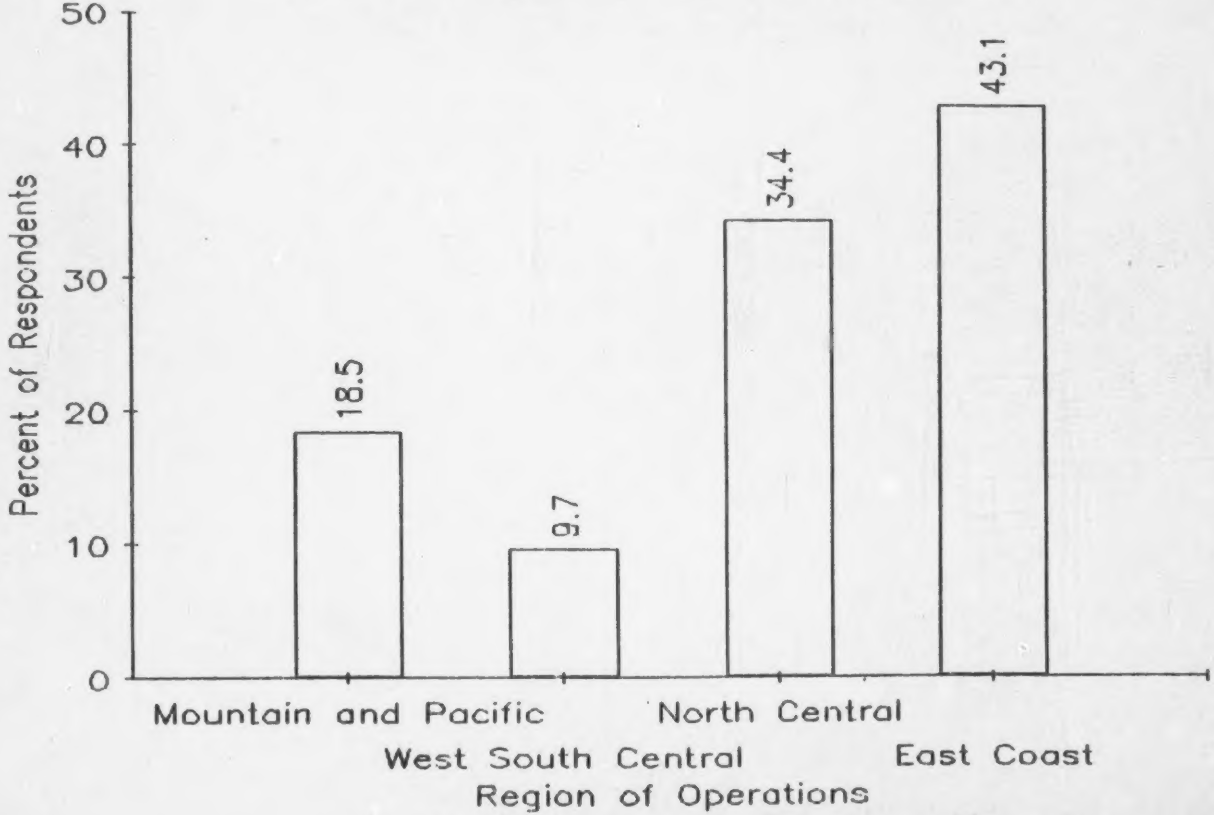
THE Wyatt COMPANY

FMI 1987 Benefits Survey
Number of Stores Operated by Respondents*



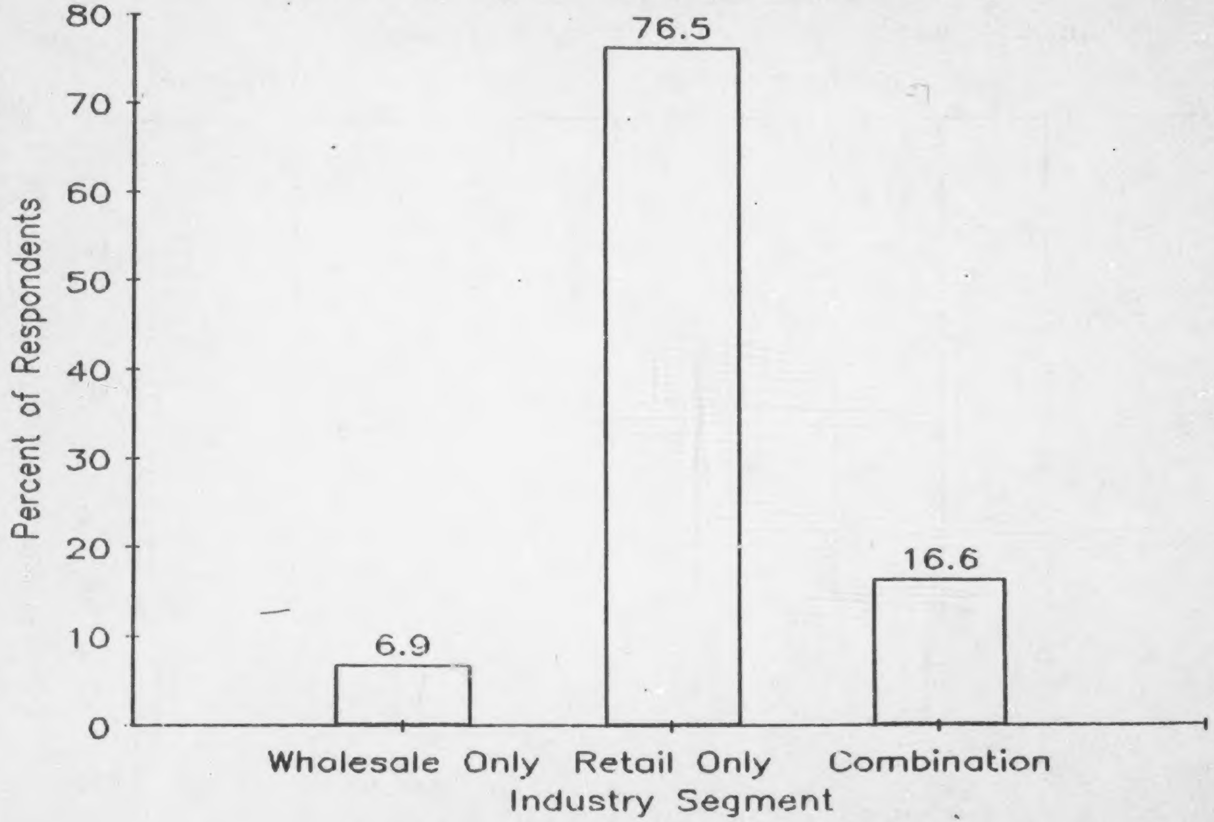
* These are preliminary data subject to revision

FMI 1987 Benefits Survey
Location of Operations of Respondents*

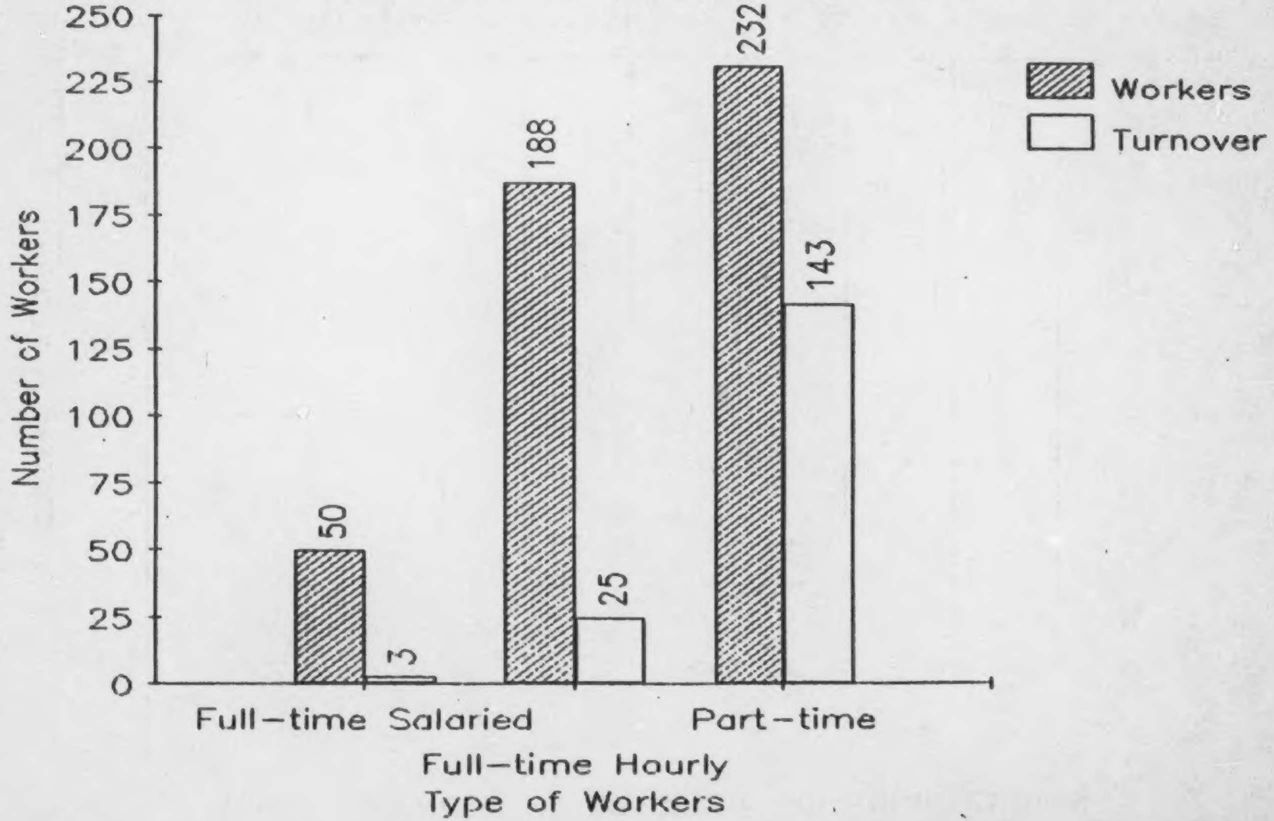


* These are preliminary data subject to revision

FMI 1987 Benefits Survey
Nature of Operations of Respondents*

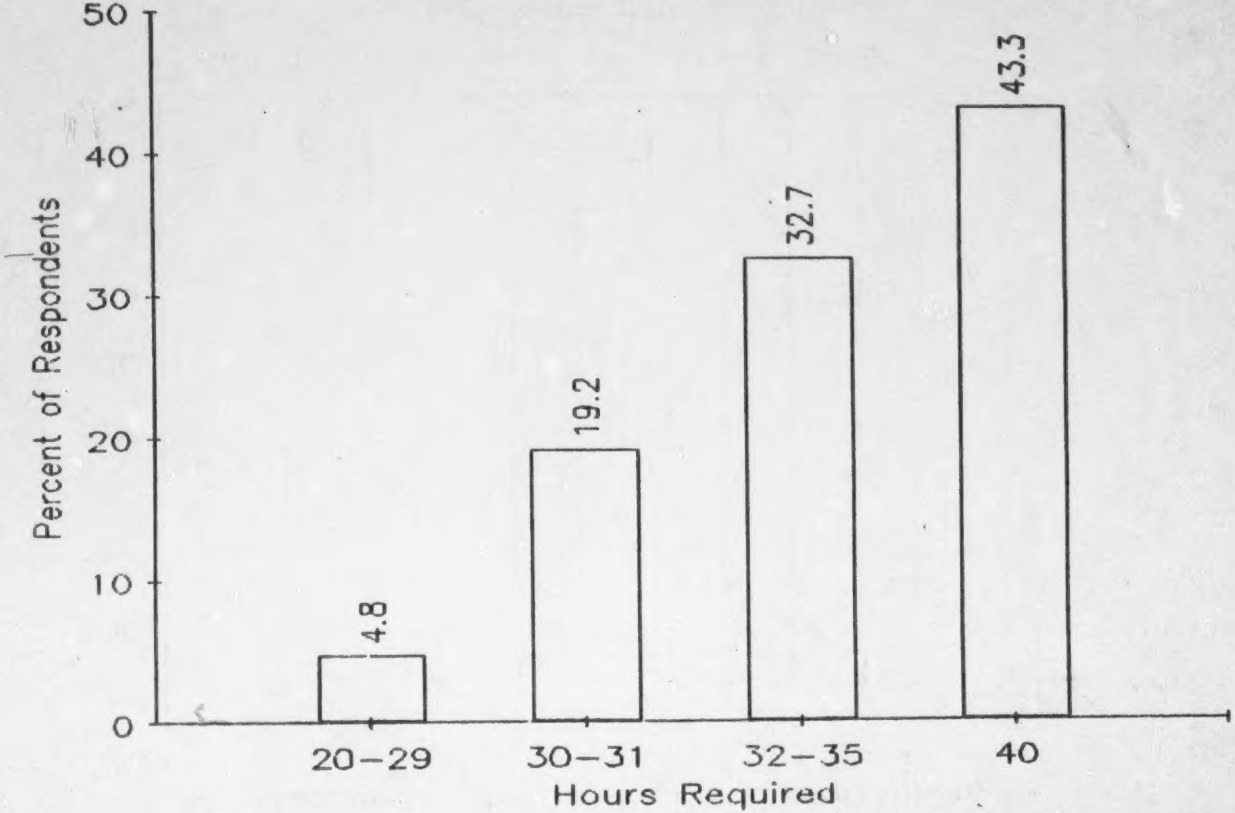


* These are preliminary data subject to revision



FMI 1987 Benefits Survey
Median Number of Workers and Turnover*

* These are preliminary data subject to revision



FMI 1987 Benefits Survey
Hours per Week Required for Full-time Status*

* These are preliminary data subject to revision

FMI 1987 Benefits Survey
Profile of Typical Workers*

	Age	Service (Years)
Full-time salaried	26–40	8 or more
Full-time hourly	26–40	1–7
Part-time	Under 21	1–4

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*These are preliminary data subject to revision

FMI 1987 Benefits Survey

Prevalence of Benefits Provided by Respondents*

	Salaried Workers	Hourly Workers
Health Benefits	97.4%	96.8%
Catastrophic Coverage	81.7%	
Long-term Disability	62.9	45.1
Short-term Disability	72.3	74.4
Life Insurance	95.4	93.8
Dental Benefits	76.9	76.9
Retirement/Savings Plans	71.3	71.8

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*These are preliminary data subject to revision

FMI 1987 Benefits Survey
Health Benefit Plan Characteristics*

	Salaried Workers	Hourly Workers
Median Deductible		
Individual	$ 100	$ 100
Family	300	225
Median Co-payment Rate	80%	80%
Median Employer Cost Reported Per Person	$1,400	$1,200

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*These are preliminary data subject to revision

FMI 1987 Benefits Survey
Health Benefit Plan Characteristics*

	Salaried Workers	Hourly Workers
Benefit Provided	97.4%	96.9%
Eligibility Requirements		
Immediate	15.3%	5.2%
1-3 months	75.0	77.1
4-6 months	5.7	9.7
6+ months	4.0	8.0
Hours of work required per week for eligibility		
Median		32
Mode		40

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*These are preliminary data subject to revision

FMI 1987 Benefits Survey
Effects of COBRA on Health Benefit Programs*

Plans Changed Because of COBRA	13.1%
Plans Discontinued	0.5%
Service Requirement Lengthened	4.1%
Co-insurance Amounts Changed	4.1%
Other Plan Elements Changed	3.6%
Sponsors Reporting Increased Plan Costs Because of COBRA	16.8%
Percent of Departing Employees Choosing to Continue Benefits	
None	26.0%
Less than 10%	13.0%
10-24.9%	25.0%
25-49.9%	17.0%
50-74.9%	10.0%
75% or more	9.0%
Median	14.1%

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*These are preliminary data subject to revision

FMI 1987 Benefits Survey
Maternity Benefits Provided*

	Full-time Workers	Part-time Workers
Leave paid directly by employer or through an insurance plan	80.0	39.5
Unpaid leave with health coverage	53.5	28.8
Unpaid leave without health coverage	47.7	64.5
Employees can take additional leave without pay	75.4	63.1
Job is guaranteed	77.8	57.4

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*These are preliminary data subject to revision

Senator **Weicker**. Mr. Ugoretz.

Mr. **Ugoretz**. Thank you, Mr. Chairman, Members of the Committee.

My name is Mark Ugoretz. I am the executive director of the ERISA Industry Committee, also known as ERIC, on whose behalf I appear today.

ERIC represents over 100 major corporations providing comprehensive health, retirement, and other welfare benefits to some 8 million employees and their families. ERIC's membership is made up exclusively of major employers, all of whom provide comprehensive health care coverage.

Health care coverage is a remarkable success in this country. Some 83 percent of civilian nonagricultural workers under the age of 65—165 million people—have health insurance coverage from some source. Of those, 80 percent—132 million—are covered by employer-sponsored plans.

ERIC companies alone provide comprehensive coverage to an estimated 10 percent of all Americans.

Until now, virtually all health legislation has been directed at increasing the burden on those who already offer health insurance coverage. Levying mandated benefits on existing health plans has increased the cost of insurance and deterred many employers from offering health coverage in the first place.

S. 1265 is a departure from mandated benefits legislation, such as risk pools, catastrophic care, and other specific mandated benefits.

Some large employers find the concept of universal employee coverage in S. 1265 attractive. Because hospitals, doctors and other health providers add to their bills the cost of uncompensated care, those employers who provide health care coverage bear the substantial burden of those who do not. Thus, the requirement for universal employer coverage has appeared to some, although by no means all, large employers.

Several other provisions of S. 1265 are appealing to employers. The bill provides for preemption of employer's health care plans from over 600 costly State-mandated benefits, a principal concern for all major employers. Such state controls are costly, impede uniform plan design, interfere with collective bargaining, and make it far less likely that employees will obtain the benefits they want, as opposed to those a State determines they will get.

We also recognize that the concept of actuarial equivalence of benefits in S. 1265 would provide for necessary flexibility in employer plan design and that the bill affords small employers with necessary economies of large group arrangements by making regional group coverage available under Federal control.

The bill also recognizes the need to avoid costly mandates in the future by requiring economic and health impact statements before consideration of mandated benefit legislation. This provision, as others need to be strengthened.

We feel more must be done to make S. 1265 more effective and more affordable. The combined structure of the 20 percent limitation on copayments, deductible limits of $250 and $500, inclusion of a $3,000 out-of-pocket limit, the requirement for employer payment of 80 percent of premiums and of 100 percent of premiums for lower-paid employees is too expensive for many employers, including many major employers.

The actuarial equivalency provisions in this regard are of little value because the base is still, in the aggregate, too high. As a result, the addition of non-core benefits that workers will want will be inhibited, and the willingness by employers to explore new options for services and delivery systems may be stifled.

In short, we would urge that the requirements of minimum coverage be kept extremely basic. We also oppose the inclusion of any specific mandated benefit and believe that prenatal and childcare ought to be part of a separate arrangement between employers and their employees.

Many of our members have found that the bill's requirement that employers provide health coverage for those who work more than 17½ hours to be too costly and unreasonable. Many employers who provide jobs for part-timers will find the cost of employment prohibitive; indeed, it could well double their current health care costs and may result in the elimination of some of those jobs.

Mr. Chairman, we hope that S. 1265 heralds some new thinking; that it redirects the health care debate so that we are no longer arguing about new burdens on those who already provide benefits, and instead, as this bill would appear to provide, we should be seeking effectively and economically to extend health care protection to those who are not now covered.

While ERIC has not taken a position for or against this bill until we can assess its impact specifically on our members' plans, we look forward to working with you and the Committee staff.

Thank you very much, Mr. Chairman.

Senator **WEICKER**. Thank you very much.

[The prepared statement of Mr. Ugoretz follows:]

ERIC

THE
ERISA
INDUSTRY
COMMITTEE

STATEMENT OF

THE ERISA INDUSTRY COMMITTEE

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

HEARING ON

THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987 (S.1265)

JUNE 24, 1987
WASHINGTON, D.C.

WITNESS:

MARK J. UGORETZ
EXECUTIVE DIRECTOR
THE ERISA INDUSTRY COMMITTEE

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INTRODUCTION

Mr Chairman, members of the committee, my name is Mark Ugoretz; I am the Executive Director of The ERISA Industry Committee, also known as ERIC, on whose behalf I appear today. ERIC represents over 100 major corporations providing comprehensive health, retirement, and other welfare benefits to some 8 million employees and their families. ERIC's membership is made up exclusively of major employers, all of whom provide comprehensive health care coverage to their employees.

We appreciate the opportunity to testify before the committee this morning as well as the opportunity to have been consulted over the past several months in the development of S.1265. The Chairman and his staff have been extraordinarily open to the public in their drafting of this bill and we commend them for their effort to consult with the widest possible sources of information. We believe that, as consideration of this legislation continues, the best possible result for all Americans will come from that open process.

Our comments today do not reflect an in-depth review of "The Minimum Health Benefits for All Workers Act of 1987" (S.1265). This is complex legislation which may substantially intrude on complex and diverse health care plans already established by thousands of employers. For that reason alone, it will take some time and effort to determine its actual effect on employers' existing health care plans. That effort is currently underway as our members compare their health plans with S.1265 and analyze its effect. Our comments today, therefore, reflect our initial reactions in our efforts to assist the committee in its further deliberations.

BACKGROUND

For the majority of Americans, the delivery of health coverage is a major success story. Almost all individuals over age 65 enjoy a strong base of coverage through Medicare. Many of these individuals also receive additional protection through employer-sponsored retiree health plans. Of the 200 million civilian nonagricultural individuals under age 65, 165 million, or 83% have health coverage from some source.

Of the individuals under age 65 with coverage, 132 million, or 80%, derive their coverage from employer-sponsored plans. Most, if not all, major employers provide coverage to their workers. ERIC member companies alone provide coverage to well over 10% of all Americans. Even among small employers (fewer than 25 employees) 37% of workers are covered under their employer's plan.

Health coverage cuts across income lines. In 1984, 73% of workers with annual earnings of less than $10,000 had health care coverage.

Nevertheless, 37 million Americans under the age of 65 remain uncovered by any health plan. Those who are uncovered may delay obtaining adequate care, obtain charity care or go without care altogether. The result is both poor health care and higher costs for that care.

Given the success of voluntary, employer-subsidized health coverage, attention has focused on the fact that 52% of those currently uninsured are in families of steadily employed full time workers. An additional 8% are in families of steadily employed part-time workers. While health coverage under employer plans has continued to grow, that growth has not kept up with recent growth of the labor force. From 1982 to 1985, the number of workers grew 7%; coverage under employer plans grew only 5%.

In addition, while most individuals at all income levels have health coverage, among those who do not have coverage, two thirds are in families with incomes below 200% of the poverty level and 75% of uncovered workers earn less than $10,000.

76% of uncovered workers are self-employed or are employed by businesses with fewer than 100 workers.

"MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987" (S.1265)

In seeking a solution to the problem of the uninsured, S.1265 would require that all employers provide minimum health care coverage for virtually all employees and that all employees accept such coverage. This requirement is qualitatively different from other existing and proposed state and federal legislation which mandates that existing health care plans provide additional benefits on top of the benefits already provided. Under those measures, employers who already offer health care coverage are targeted with additional burdens that increase the costs of coverage and that preclude benefits that employees want and need in favor of government required benefits. The major impact of such mandates has been (1) to increase the cost of the benefits mandated, (2) to discourage the development of additional plans and, (3) reduce the likelihood of additional coverage to millions of workers and their families.

On its face, S.1265 seeks to avoid the pitfalls of earlier mandated benefit legislation that merely adds to the burden of those companies already offering health care coverage. We hope that it will herald the end of such legislation. Clearly S.1265 changes the debate: no longer should we be discussing new burdens on those who already provide benefits; instead we should be seeking effectively and economically to extend the advantages of health care coverage to those who are not now protected by it.

By attacking the real social problem -- lack of any coverage -- rather than responding to providers and other interest groups, S.1265 correctly moves away from traditional mandated coverage. If a benefit requirement is indeed necessary, then an affordable minimum basic benefit, directed to those who do not now enjoy coverage, is clearly more effective than adding new burdens on those who already provide coverage.

ERIC OPPOSITION TO MANDATED BENEFITS IN GENERAL

ERIC members, and indeed virtually all employers, have been universally opposed to mandated benefits. We object, therefore, to the provisions in S.1265 which mandate prenatal and well-baby care in a way not provided in many comprehensive benefit plans. We strongly believe that health benefits ought to reflect the specific needs of employees and not a political judgement placed ahead of plan design. Certainly we do not believe that it is an appropriate provision in a minimum health care proposal. It is an example of the kind of mandated benefit that employers fear would follow enactment of minimum coverage legislation.

Mandated benefits require an employer to provide coverage for items he might not otherwise cover and that its employees do not necessarily need or want. Over 600 separate state mandated benefit laws require insured health plans to cover specific services such as alcoholism treatment or in-vitro fertilization, to reimburse specific types of providers, to expand the length of time that coverage is in effect, and to include additional beneficiaries under an employer's plan.

All employers have limited resources for their benefit programs. Mandating specific coverage results in fewer dollars available for basic coverage, it forces onto workers a greater share of the cost of basic health care in exchange for boutique arrangements, and it reduces monies available for wages. A recent survey by Travelers Insurance found that additional costs imposed on plans through state mandated benefits adds up to 15%

to the cost of health care coverage. An additional 1985 study showed costs of major medical coverage increased as much as 27% due to specific state benefit mandates.

Those costs are becoming more and more important. The U.S. Health Care Financing Administration (HCFA) recently reported that the nation's health care bill, now over 10% of GNP, will grow to 15% of GNP in less than 15 years. The new costs have been attributed to greater consumption of health care while the health care we are consuming is costing more each year.

Mandating specific benefits may also impinge on the ability of American manufacturers and marketers to stay competitive with foreign counterparts. To the extent that American employers lose flexibility and the ability to respond economically to foreign competition, the cost of production and distribution of American made goods will increase compared to those made in Europe and Asia. American automobile manufacturers, for example, estimate that over $500 of the purchase price of even basic models represents the cost of health care.

Ultimately, as the cost of health care benefits adds to the cost of employment and thus the cost of production, employers may be forced to cut back on domestic employment, the cost of benefits having impaired their inability to compete from American shores in highly competitive global markets. On the other hand, most companies competing in international markets already provide health care coverage to their domestic employees. To the extent that S.1265 does not impose new requirements on these companies, it would not appear to affect their ability to compete.

There is simply an absolute limit to the resources available for benefits and indeed for employment. If companies are required by legislative fiat to provide for chiropractic care, alcoholism and drug abuse, hospice care and a variety of other benefits -- however laudable -- and if they also have to provide for the increasing costs of special providers and mandated diseases and conditions, then fewer resources will be available for basic health care and, ultimately, compensation.

CURRENT CONSIDERATION OF FEDERALLY MANDATED BENEFITS

Even though the proliferation of specific mandated benefit laws has clearly discouraged or prevented employers who must use insured arrangements from offering health plans to their employees, the federal government in recent years has also taken steps in the same questionable direction.

Continuation coverage requirements included in COBRA overlapped similar provisions in plans or requirements in state laws, ensured negative selection in coverage, and thereby increased both administrative and benefit payment costs for employer plans while adding new layers of complexity.

Legislation now before the Ways and Means Committee, H.R. 2300, mandates that all employers who offer health plans for 20 or more employees include specific out-of-pocket dollar limits on employee expenses. In fact, the legislation would seriously disrupt or outlaw common cost-containment procedures, require substantial plan design changes in many instances, and subject employers to open-ended liabilities which can only discourage employers from offering coverage in the first place.

In addition, Congress has under consideration legislation that would require employers to provide for parental leave, full pediatric care, mandatory coverage for part-time and temporary workers, and indemnification of state mandated risk pools. The aggregate affect of this legislation, in conjunction with other state and federal mandated benefits, will be a heavy burden on businesses which are labor intensive, low-margin, or rely substantially on part-time, temporary workers, or seasonal employees.

THE INTENT OF S.1265

By looking wholly to those who are not now covered by health insurance, the intent of S.1265 is to avoid increasing the burden on those now providing coverage. Thus, if the bill does what it is supposed to do, it ought not increase the costs of nor otherwise interfere with the health plans of those who are now providing basic health care coverage. Any minimum benefit bill should be aimed at increasing coverage and avoid provisions which discourage employment or the formation of new plans.

Of course, such legislation means an additional expense to employers who are not now providing coverage and that expense will be passed on to their customers and ultimately to the public. It may also mean that they cannot afford the cost of doing business and may close. For example, employers reckon that the requirement to provide health care to part-time and temporary employees could increase the cost of such employees by 40 to 50%. At least one major labor intensive employer has done a preliminary analysis of his health care plans and estimates that coverage of part-time and temporary employees would double the cost of coverage from $30 million to approximately $60 million.

We strongly believe that a government requirement that one party provide a costly and substantial benefit to another party should be undertaken only after it is clear that all other options will not work, particularly where the government bears little, if any, fiscal responsibility for the cost of imposing that requirement.

Thus, S.1265 is a major step. Before government imposes this or any other burden on employers to provide benefits to their workers, other avenues should be explored. Expanding eligibility for Medicaid, increasing tax incentives for small business, eliminating costly state mandated benefits by way of a more comprehensive preemption provision than that which is in the Employee Retirement Income Security Act (ERISA), and enhancing the ability of employers to band together on a regional basis to obtain the benefit of large group coverage may also substantially improve coverage without imposing a broad federal requirement for minimum health care coverage on all employers.

For example, analysis of the population currently without health coverage indicates that substantial improvement in national coverage could also be accomplished through expansion of the Medicaid program. Data compiled from the 1986 Current Population Survey indicates that coverage under employer plans of all employees working 18 hours or more a week and their dependents would result in coverage for 22.9 million currently uncovered individuals. However, covering all individuals in families with incomes of 200% of the poverty level or below under Medicaid would result in 21.6 million people without health care protection being covered. Although these two populations are not identical, there appears to be a large overlap between them. While ERIC does not take a position today on such a substantial expansion of the Medicaid program, the statistics indicate the potential range and mix of options.

If minimum health care legislation is in fact necessary and appropriate, S.1265 properly requires that all employers must be responsible for their own workers, thus avoiding the current and not uncommon practice of some employers shifting the burden of their employees health care coverage to their spouse's plan, sometimes offering a "bounty" to do so. S.1265 also would preempt state mandated benefits which result in high health care costs and reduced flexibility, and act as a deterrent to the establishment of new health care coverage.

CAN MINIMUM HEALTH CARE COVERAGE WORK?

If the decision is made that a government required employer-provided minimum health care package is a necessary part of health coverage, we believe the following are critical principles that must be followed in order for such a program to work:

The requirement must be imposed on all employers and all employees must participate.

The required package must be truly a minimum one. It must be affordable even for marginal or new businesses.

The law must include procedures that will make it difficult, if not impossible to expand the required package beyond the most basic coverage.

Mechanisms must be established to allow small employers to enjoy the cost efficiencies of large groups.

State mandated benefits must be preempted.

Employers must have maximum flexibility to meet the needs of their workers, the demands of cost containment, and the ability to compete domestically and abroad.

FEDERAL PREEMPTION

ERIC urges a strong and effective preemption provision in S.1265. While ERISA preempts state laws in virtually all aspects of employee benefits, it excepts from the preemption-provision state control of the business of insurance. Thus, while insurance may be regulated by the states, if an employer provides self-funded health coverage for his workers and meets the fiduciary and reporting requirements of ERISA, he is exempted from state control and state mandates.

Over the past several years, exemption from state control has been no small consideration. Preemption allows an employer to design a plan that provides the coverage its employees want; it means that labor and management can work out a collective bargaining agreement on benefits; and it means that employers with operations in several different states can develop uniform benefit plans consistent with the needs of their workers and their own requirements.

Thus, preemption precludes the imposition of costly benefits that neither employers nor employees need or want. Preemption is therefore imperative to any minimum coverage proposal. Without a preemption provision, state mandated benefits would open the door to a patchwork quilt of diverse, varying, and inconsistent state legislation and regulation that would make a sham of any minimum coverage health legislation.

We therefore welcome the inclusion of a preemption provision in S.1265 and are reviewing its effect on our members' plans.

Our initial reaction to the preemption provision in S.1265, however, is that it may be interpreted to exclude plans which offer anything greater than a minimum benefit, leaving to current law virtually all existing employer plans. If that is the case, we strongly urge that the language be corrected to provide that all plans offering at least the federal minimum benefit be protected by the preemption provision.

COST CONTAINMENT

Minimum health care legislation also requires an effective cost containment mechanism that precludes the easy or ready imposition of mandated benefits. Thus, the Section 402 "policy respecting additional benefits" is welcome although we believe that section should be substantially strengthened.

While Section 402 requires that "Congress shall request a report from the Office of Technology Assessment (OTA), [or] the Institute of Medicine of the National Academy of Sciences" it permits a request, in the alternative, to any other "public or nonprofit entity with expertise relating to health benefits." We would urge that such language should, at minimum, be amended to require a report from OTA and some other appropriate government agencies in a position to independently analyze the proposal, a position which any other "public or nonprofit entity," may not enjoy. Indeed, requiring a report from any "public or nonprofit entity" may only require what is already a practice in virtually any congressional hearing or inquiry.

The intention in S.1265 to preclude any employer from being required to provide any health benefits in addition to those in this bill, unless they are also provided by the Medicaid program, is an effort to make Congress fiscally responsible for any mandated benefits offered in the future. We agree with that proposition and urge that further efforts be explored as well to preclude expansion of what is intended to be a minimum health care package.

We also believe that section 402 should also preclude amendments to the Internal Revenue Code that would bar tax deductions for health care coverage under the Internal Revenue Code unless an employer provides some specific mandated benefit in his plan.

We are also concerned that S.1265 fails to limit an employer's liability to "reasonable and customary" charges. Unless such a safeguard is included, even a minimum health plan would be subject to unreasonable costs.

CONCLUSION

Mr. Chairman, we appreciate the opportunity to work with you and your staff on efforts to provide health care coverage to those who do not now enjoy such protection. We look forward to continuing to work with you, your committee, and the staff.

Thank you.

Senator WEICKER. The questions that I have and comments I have certainly can be responded to by any of you, but first, let me make one comment relative to, as Mr. Rudd said, the precipitousness of this legislation.

The deliberations on this legislation commenced in December, and believe me, Senator Kennedy's staff and my staff and others had open doors to anybody who wanted to have input. And I think it is fair to say—it is fair to say—that almost everybody in the business community, at least those various organizations, stepped forward and did have input, albeit—albeit—saying that they were doing so with no guarantee that when the final product came to pass that they would go ahead and endorse it. And that was clearly understood.

But this is as much advance work and advance notice as any legislation that I have been associated with in the few years that I have been around here. So I want to make it very clear—and this is the second hearing on this—but the hearing calendar is not as important as to point out that we have been at this now for about seven months, and this is still part of the process, without any vote being taken in the subcommittee or committee or whatever-have-you.

The second point was addressed in some of the testimony here, but I would like to have Bob Patricelli and Mr. Rudd address themselves to it especially. And that is that almost the assumption that for some reason or other, there is a system out there that is not costing anybody anything to take care of these 38 million people.

Well, somebody is picking up the tab under a disorganized system, a system that has no equity in it, and yet the costs are there, and how do you respond to that? It is not a question that this is just being taken care of by voluntarism, it is being taken care of by some Federal programs, some State programs, some local communities, et cetera. It is being taken care of, very frankly, by employers who do have health care systems in place. Do you think that kind of system is preferable to trying to get this matter organized and on-track?

Mr. PATRICELLI. I will respond if I may, Senator. It is true that these costs are being paid by someone. There is no such thing, truly, as uncompensated care. Somebody is compensating for the care.

However, the answer in the Chamber's view is not to mandate the extension of employer coverage, but to look at the sources of so-called uncompensated care and deal with them flexibly and in different ways as each source requires.

A large part of that problem is created, for example, by less than full payment by the Federal Medicare/Medicaid Programs to providers, who then cost-shift to the private sector.

Another part of the problem is the result of gaps in the Medicaid Program, as I suggested, and the Chamber would support a rationalization of the Medicaid Program.

Another part of the problem could probably be dealt with through State-based risk pools that would permit the medically uninsurable to gain coverage without an employer mandate.

Finally, Senator, I would say that I find the concern expressed by some large employers that this bill should be supported because they are carrying the burden for a number of small employers who do not offer coverage, in my mind, somewhat exaggerated.

I believe the facts would show that the largest portion of uncompensated care that large and small employers are both paying for through cost-shifting does not result from lack of coverage among small businesses, but from the government programs not paying their full share and from cost-sharing within current employer programs, which cost-sharing is leading to employee bad debt in the system. And in fact, big business is probably gaining more by way of cost-shifting because they drive better discounts with providers and have more experienced-rated insurance programs than small business is.

So I would like specifically to rebut the contention that a correction is needed here between the burdens on small and large business.

Senator **Weicker**. Mr. Rudd.

Mr. **Rudd**. Senator Weicker, I agree with what Mr. Patricelli has said. The only additional thing I would add is that there are a myriad of structures—such as the tax-exempt hospital, which has a governmental subsidy—which can help provide care in these kinds of situations. That, in conjunction with many of the other charitable organizations, provide vehicles for taking care of these people. But my concern, Senator, is with the fact that we do not want to kill the goose that lays the golden egg for all of us. And there are many, many employers out there that are teetering on the edge of failure right now.

Our industry does not represent the American Airlines of the world and the Baxter Travenol Laboratories. We represent the small, independent grocer with between 50 and 100 employees. And these are the people that simply could not assume that additional cost burden, which is compounded by the fact that once that person becomes eligible for their benefit plan, they then have to extend it to him for 18 months beyond his termination. They simply could not incur those additional costs without either dramatic increases in their price structure, which makes them uncompetitive, or teetering on the brink of failure.

And I am just concerned that in all of our concern that we kill the goose that lays the golden egg for all of us.

Senator **Weicker**. Well, I suppose that what worries me are the part-time workers at Albertson's, let us say, who become ill—who is expected to take care of them?

Mr. **Rudd**. Virtually all of our part-time employees, Senator, are dependents of other full-time employees. Virtually all of our part-timers are people between 16 and 21 years of age who are parts of other households, that are dependents of people with coverage.

They just are not part of this huge pool of uninsured people that we are talking about.

Senator **Weicker**. Mr. Goldbeck, would you comment on this last statement here?

Mr. **Goldbeck**. Well, I suspect that if I were Boise Cascade's benefit manager from Idaho, I would note that a lot of those are the dependents of Boise Cascade workers with good coverage, and therefore it is Boise Cascade that is paying for the benefits of Albertson's part-time workers.

I obviously do not know specifically about this gentleman's immediate dependents, but that is a model of what does in fact happen in a great many instances around the country and which represents the kinds of concerns that a Chrysler or some of the others you have heard about express.

It also is equally true, for a small business that did provide health insurance and had a dependent who was working for another company that did not provide health insurance. You in effect are paying part of the other firms compensation costs.

These benefits are part of compensation; they are not unconnected to the total per-employee cost. They are not some gift. And the employee is intimately connected to that benefit, that compensation. So in all of these cases, whether they be big or small employers, the issue is whether or not somebody should be working in one place with another employer paying for their medical care.

What you will be hearing from many is that the answer is "No." From others, the answer is "That is terrifically beneficial for our company right now; why change it?"

Senator **WEICKER**. Mr. Rudd, are all the employees of Albertson's—full-time, part-time—all the employees covered by health insurance supplied by Albertson's?

Mr. **RUDD**. Mr. Chairman, all of our employees, by virtue of the nondiscrimination provisions of the Tax Reform Bill of 1986, down to 17½ hours per week are covered. Most of our union contracts require coverage for employees down to 20 hours a week.

I would say virtually all of our part-time employees—and I would hazard a guess of 90 percent or more of our part-timers—are covered by a health plan.

Senator **WEICKER**. Mr. Ugoretz, do you have any comment on this general discussion that has been taking place here?

Mr. **UGORETZ**. Yes indeed. Many of the employees that are being cost-shifted are being cost-shifted to major employers.

I would also note that according to the Small Business Administration, a substantial number of small employers, already provide health care coverage: 46 percent of firms with one to nine workers; 70 percent of the firms with 10 to 24; 92 percent of the firms with 25 to 99. Thus, many small businessess are victims of cost shifting also.

I would submit to the Committee, however, that it is worth spending some time in developing some alternatives for small business as well as others within this bill, for two reasons.

One, there may well be an alternative to such a requirement; and second, in exploring alternatives, we may find some possible mix between a mandated requirement and increased Medicaid buy-ins, for example, that could be worked into the bill to make the coverage more affordable to employers.

Senator **WEICKER**. On that point, I can assure you that we are not going through a pro forma exercise here. If you have recommendations such as that, I know Senator Kennedy and myself and the others on the Committee really would like to have them before we go to a final markup on this bill.

And indeed, we spent months trying to elicit alternative suggestions. We got some, but I must confess there were not too many. So I would greatly appreciate any advice you have in this regard. This is not a closed matter that you are coming here to testify on. You are here because we are looking for your advice.

You are right, whoever made the statement, either on this or the earlier panel—this is landmark legislation. And obviously, anything of first impression is going to have its defects, but at least we can try to minimize the number of defects that are going to go ahead and occur by turning the best minds, and we have that before us right now.

The only comment I would not accept, and I am advising my friends in all phases of industry and business and those that are impacted by legislation, is we do not want anything; anything is the one thing that is not going to happen, or not anything is the one thing that is not going to happen.

Yes?

Mr. **Goldbeck**. One comment that you heard is also in our written statement and probably does deserve some pretty specific attention. From the standpoint of small business, particularly those who you are asking to start a new benefit, but even from the larger companies, major opposition is caused by the dual impact of S. 1265 and the COBRA benefit extensions.

One of the reasons that S. 1265 is potentially a landmark piece of legislation is because it sets out to redefine responsibility for the provision of a health care service and its financing. In so doing it is built upon a principle that the primary responsibility of employers should be their employees, workers and their dependents while working.

If you are going to get close to the passage of S. 1265 or some version thereof, it really does suggest a reexamination of the degree to which those same employers should then also be held responsible for people who are not in the work force. Those benefit extensions may have been good public policy when there was no requirement for health insurance amongst employers for their own workers. But, once you establish a national standard and mandate for employers to cover their workers and their dependents, then it does suggest that there should be a reexamination of who should be responsible for nonworkers, for how long, and under what conditions.

Senator **Weicker**. Mr. Rudd.

Mr. **Rudd**. Mr. Chairman, the impact of this legislation falls most heavily on labor-intensive industries. Our problem is totally different in the service industries, the retail industries, than it would be for American Airlines or Chrysler, or a capital-intensive industry.

We have a combination of a lot of entry-level employees, high turnover, and a lot of part-time people. Anything that we could do to minimize the adverse effect on these companies by raising the definition of part-time employees, for example, to 30 hours, increasing the waiting period from 30 days to a reasonable period, increasing the permissible copayment, would reduce the impact of that legislation and would make it less onerous to the small businessmen. And the reason we are concerned is because of all the industries represented here today, we are most heavily impacted by the impact of the part-time employees, and that is one of our chief concerns.

Senator **Weicker**. I appreciate those comments.

I have other questions from Senator Kennedy and other Members of the Committee for response for the record. Otherwise, I thank you very much for your giving of your time, and I truly look forward to having further communication with one or more of you on this subject.

Thank you very much.

Our next panel consists of the spokespersons for the two national leading insurance associations, Blue Cross/Blue Shield and the Health Insurance Association of America.

Bernard Tresnowski is the President of Blue Cross/Blue Shield, and Carl Schramm is President of HIAA

Gentlemen, it is a pleasure to have you.

Mr. Tresnowski, why don't you proceed?

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, IL; AND DR. CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC, ACCOMPANIED BY KAREN WILLIAMS, DIRECTOR, RESEARCH DEPARTMENT, HIAA

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman.

I have a full statement and I would ask that it be introduced into the record, and I will be very brief and summarize.

The issue which this Committee is considering today, how to provide health coverage for, depending upon what estimates you select, 35 or 37 million Americans who now lack such coverage, is a matter of central policy concern and of special concern to the Blue Cross and Blue Shield organization.

The proposal that is described in S. 1265 focuses on the heart of the problem—the inability of many low-wage workers and their families to afford health coverage and small employers' difficulties in obtaining affordable health benefits for their employees.

In our analysis of this situation, we have found that far more than any other factor, low-wage workers are uninsured because they cannot command both adequate wages and employer-provided health benefits.

Also, the uninsured are concentrated among persons employed by small employers. About two-thirds of workers and firms which do not sponsor health insurance are in firms with fewer than 10 employees, and 84 percent are in firms with less than 25 employees.

Small employers face higher health benefit coverage costs for a whole variety of reasons, an extremely complex matter—market segmentation, adverse selection, dilution of the risk pool, and a lack of actuarial credibility for these employers.

In addition and most importantly, when small businesses purchase coverage, they have the cost of State-mandated benefits included in their premiums, a point that has been made all morning long. This drives the per-employee cost higher than for larger employers who have, in many cases, self-funded their employee coverage to avoid such mandates and their costs.

Small businesses also indirectly pay State insurance premium taxes and high risk pool assessments, while ERISA preempts most large companies from these expenses.

Another factor which adversely affects small employers is that the tax treatment of their health coverage expenses can be less advantageous than for large employers. As has been said here this morning, unincorporated businesses such as sole proprietorships and self-employed persons have not been able to deduct their full health coverage from taxable revenue as can corporations.

S. 1265 recognizes the key element of the uninsured problem—the inability of low-wage workers to command employer-provided health benefits.

We are concerned that S. 1265's mandated employer costs could adversely affect some workers and their families, and we have outlined our concerns on that score in my full testimony.

However, we are most concerned about the proposal's regional pool arrangement. While artificially creating a very large pool is an attempt to spread risk and administrative costs, the savings are likely to be illusory.

One reason is that by limiting the number of companies which could offer coverage, true competition would be eliminated. Because of the very large size of the contracts, those who initially won the regional contracts would likely keep them because of an absence of competition. Consequently, the price of coverage would not be driven down or moderated through competition, as predicted.

Secondly, by still having a sizable number of options, the movement of employer groups from one option to another would create the same turnover problems that we have under the current system.

What do we do in the meantime?

In our testimony we have outlined some recommendations which would take us toward the same goals of S. 1265. We believe that these changes would offer new opportunities for our Blue Cross and Blue Shield Plans and employers to work together to solve some of the uninsured problems. Most of these have been mentioned this morning—establishing national uniform Medicaid eligibility standards; allowing a buy-in to Medicaid for the full-time low-income worker; as I mentioned, changing ERISA; establishing risk pools for the medically uninsurable; and changing ERISA so that self-funded companies would have to participate in those State risk pools; and finally, a reference earlier this morning to provide the same 100 percent tax deduction of health coverage premiums for unincorporated business, sole proprietorships, and self-employed.

In summary, Mr. Chairman, we do share the conviction of you and Senator Kennedy that the private and public sectors must build new partnerships to assure that every American has adequate health care coverage. By stimulating this debate and discussion, we have begun deliberate work and expect to work with this Committee and its staff to meet these common objectives.

Thank you very much.

Senator **Weicker**. Thank you very much.

[The prepared statement of Mr. Tresnowski follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

on

MANDATED EMPLOYER HEALTH INSURANCE

before the

LABOR AND HUMAN RESOURCES COMMITTEE

UNITED STATES SENATE

by

BERNARD R. TRESNOWSKI
PRESIDENT

June 24, 1987

Mr. Chairman and Members of the Committee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association, and I am appearing at this hearing on behalf of the nation's 77 Blue Cross and Blue Shield Plans.

The issue which this Committee is considering today - how to provide health coverage for more than 35 million Americans who now lack such coverage -- is a matter of central concern for national health policy and for the Blue Cross and Blue Shield organization. Over the past 50 years, Blue Cross and Blue Shield Plans have pioneered in the development of private health coverage and in administering public health coverage programs.

We are concerned as you are about the trend of the past decade -- a rise in the uninsured population from 25 million to more than 35 million Americans. Down this road lies even more financial hardship, less access to needed medical care and the increasing number of health problems that result when people avoid needed care because they lack the ability to pay for it. It appears certain that increasing numbers of our citizens will face these problems unless the public and private sectors work together to find appropriate solutions.

Your proposals, Mr. Chairman, as described in S. 1265 focus on the heart of the problem: the inability of many low-wage workers and their families to afford health coverage, and small employers' difficulties in obtaining affordable health benefits for their employees. You are to be commended for opening debate on these important national issues. We share your commitment to increase the number of employed individuals who have adequate health coverage and to make private health coverage more accessible to small employers.

In my testimony I will discuss our view of the problems faced by low wage workers and small employers, comment on the provisions of S. 1265, and suggest ways to strengthen the private market's ability to deal with the growing problems of the uninsured.

Overview of the Problem

Blue Cross and Blue Shield Plans are involved in a wide range of efforts to make health coverage affordable to individuals and to serve small employers. We have identified many factors which determine whether an individual purchases health coverage and whether his or her employer offers health coverage and shares in premium expenses. However, we have concluded that there are two major barriers to securing adequate health coverage.

Low Wages for Full Time Workers

First, far more than any other factor, we find that low wage workers are uninsured because they cannot command both adequate wages plus employer-provided health benefits. Three-quarters of these uninsured workers earn less than $10,000 per year and more than 90 per cent earn less than $20,000 per year.

Putting these wages in perspective is the fact that a four person family earning less than $11,200 in income and a five person family with less than $13,257 would fall under the federal poverty level.

Lack of health coverage is only one of the many problems faced by low wage workers seeking to support a family. Too often, there is not sufficient money for food, housing, clothing and other basic necessities. It is clear why a low income working family would not be able to afford a health coverage premium, or even the employee's share of an employer-sponsored plan.

The difficulties in affording health coverage are even greater for part-time workers who have fewer financial resources. The uninsurance rates among full-year, part-time workers, occasionally unemployed workers and part-year workers are more than double the uninsurance rate for full-year, full-time low wage workers.

The problems of low wage workers are compounded because traditionally they receive much less financial assistance in purchasing health insurance than others would in the form of employer contributions, government insurance (Medicaid) eligibility, and federal tax support.

Low wage workers in firms where a majority of workers are paid low wages are disadvantaged not only because of their own wages but because their employer is far less likely to sponsor a health coverage plan than other businesses. In firms which do sponsor health coverage plans, only 12% of employees earn less than $10,000. In firms which do not sponsor health coverage plans, 54% of employees have salaries below $10,000 and 89% of employees earn less than $20,000 per year.

Medicaid provides adequate benefits for those who are eligible (about $2900 for a family of four in 1986) but very few in the working population can meet its qualifications. Eligibility for Medicaid coverage has declined to less than 40% of the poverty population over the past decade. States' share of Medicaid spending is at its lowest rate in more than half a century.

As part of its tax policy, the federal government appropriately encourages employers to offer their employees health benefits by not counting employer contributions for health coverage premiums as taxable income for an employee. These provisions, however, only assist workers whose employers offer health coverage and share in premium costs. Low wage workers whose employers do not sponsor employer group coverage must seek coverage through the more expensive individual market with after tax dollars.

Problems of Small Employers

A second characteristic of the uninsured problem is that it is concentrated among persons employed by small employers. And depending upon how the small employer market is defined, this sector can be quite large and diverse. Firms with fewer than 100 employees represent 98% of all businesses and account for one-third of all full-time workers. Seventy-five percent of all businesses have fewer than 10 employees and these account for 11% of all workers.

Just as firms with significant proportions of low income workers seldom offer health coverage, small employers are less likely than large employers to sponsor health coverage plans. Fewer than one-half of firms with less than 10 workers offer health insurance, compared to more than three-quarters of firms with 10 to 25 workers, more than 90% of firms with 25 to 99 workers, and virtually 100 percent of larger firms. About two-thirds of workers in firms which do not sponsor health insurance are in firms with fewer than 10 employees and 84% are in firms with less than 25 employees.

When they offer health coverage, small employers face higher premium expenses than larger employers. Some of these expenses result from insurers' unavoidable expenses such as sales and administrative costs per employee. These are higher on a per capita basis than for large employers because of the smaller group size over which to spread fixed expenses; higher servicing costs for firms without employee benefit personnel; more frequent employer movement between carriers; and greater use of seasonal and part-time employees.

Also small employers can face higher costs as a result of some health insurers' market practices and government policies. Although Blue Cross and Blue Shield Plans continue to community rate small groups, the growing market practice is to aggressively experience rate smaller firms. Smaller employers thus can be deterred from offering health coverage because they have higher premiums due to a few workers' poor health. In larger firms, such risks tend to average out. As market segmentation has increased, potential risks such as those faced by older workers, an employee's child needing a liver transplant, a spouse with a chronic illness or a worker with AIDS all contribute to small companies' inability to provide health coverage.

An additional factor which drives up small employers' costs is the provision of the Employee Retirement Income Security Act of 1974, (ERISA) which preempts self-funded employee health benefits from state mandated benefit laws. Many large companies have taken advantage of this preemption. Thus, when small businesses purchase coverage they have the cost of mandated benefits included in their premiums and this drives the per employee cost higher than for large employers. States now have more than 600 such mandate laws. Small businesses also indirectly pay state insurance premium taxes and high risk pool assessments, while ERISA preempts most large companies from these expenses.

Another factor which adversely affects small employers is that the tax treatment of their health coverage expenses can be less advantageous than for large employers. Unincorporated businesses, such as sole proprietorships and self-employed persons have not been able to deduct health coverage costs from taxable revenues as can corporations. This may help explain why fewer than one-half of the self-employed population has health coverage. While the 1986 Tax Reform Act allows a 25 percent tax deduction for unincorporated business owners this still is significantly less than the 100 percent available to corporations.

In summary, small employers face a number of difficulties which make it more expensive for them to offer health coverage than large employers.

Comments on S. 1265

The bill which this Committee is considering, S. 1265, the

"Minimum Health Benefits for All Workers Act of 1987", would address the problems of the working uninsured through the following major provisions:

(1) All employers would be required to enroll their employees (those working 17 1/2 hours per week or more) and their families in health benefit plans. These plans would be required to meet minimum standards. Employers would pay 80% of premium costs for most workers and the entire cost for low wage workers (those earning less than $4.19 per hour). Workers would be required to enroll in these plans. S. 1265 would also preempt state mandated benefits.

(2) Six to eight health insurance regions would be designated for the nation. In each region, 2 to 5 carriers would be permitted to offer approved health benefit plans. Each carrier would have to offer at least two indemnity and two managed care plans (basic and enhanced benefits). Each regional carrier could enter into subcontracts to carry out their responsibilities. After the date of enactment, all firms would have two years to select any carrier to provide health benefits to their employees. Those firms which two years after the date of the law's enactment still did not provide health benefits to employees would be required to offer one of these

> regional health benefits plans. Small employers (under 25 workers) would be required to offer coverage through a regional carrier if they changed their health coverage arrangements.

I wish to comment on three aspects of the proposal. First, S. 1265 recognizes the key element of the uninsured problem -- the inability of low wage workers to command employer-provided health benefits. It provides a minimum benefit standard intended to help assure that coverage is affordable to both the employer and the employee and it recognizes the financial needs of low wage workers by mandating full employer premium payments for workers earning less than $4.19/hour.

We are concerned that S. 1265's mandated employer costs, while well-intended, could adversely affect some workers and their families. As estimated by the Committee, these costs could average about $1,186 per worker in 1986 ($642 for individuals and $1,631 for families). Some low wage workers may receive these mandated benefits as added compensation. But we have to question whether some employers will -- to compensate for the additional cost -- reduce cash wages, change employment practices or even lay off some workers.

Adding to the potential cost problem is the likelihood that insurers would have to charge more for the benefits than estimated under the bill. There are substantial differences between "pure actuarial" estimates and what responsible carriers would need to charge initially when taking the risks of bringing major products to a new multi-state marketplace with a relatively unknown enrollment. And, there will be many areas of the country where HMOs, PPOs and managed care are available to only a small fraction of the population. Thus, care must be taken to avoid overestimating the savings from such entities.

Second, S. 1265 recognizes the reasons small employer coverage costs more on a per person basis including, the absence of the economies of scale in administrative costs. The multi-state pool arrangement clearly is designed to reduce "shopping" among carriers and the resulting high employer turnover that drives up premium costs. As we understand the effect of the multi-state pool, there would continue to be an independent large group market outside the regional pools. Over time, small groups would tend to move to regional insurers because of the provision that they could change insurers only by moving to the regional pool.

While artificially creating a very large pool is an attempt to spread risk and administrative costs, the savings are likely to be illusory for three reasons.

First, by limiting the number of companies which could offer coverage, true competition would be eliminated. After the initial contract award, those companies that were not selected could have a questionable future in the small group market. Particularly, if there were substantial movement of small groups to the regional pool, insurers would not be able to maintain their network of small group brokers and their local presence. Because gearing up for a second-round bid for such a large geographic area would be extremely costly and a high risk exercise companies would be reluctant to participate. This hesitancy on the part of carriers to make major financial commitments for large regional contracts is demonstrated well by the absence of bidders for the new regional CHAMPUS contracts. Thus, those who initially won the regional contracts would likely keep them because of an absence of competition. Consequently, the price of coverage would not be driven down or moderated through competition, as predicted.

Second, by having so many coverage options, the movement of employer groups from one option to another would create the same turnover problem we have under the current system. Further, based on our experience, the many options would quickly result in adverse selection in the pool with the healthier taking one type of coverage while the sick would opt for more comprehensive benefits. The proposal attempts to incorporate the advantages of a free market, i.e., price competition, while eliminating the disadvantages that such competition brings, e.g., market segmentation. This would be extraordinarily difficult to achieve.

Third, while it would be a one-time phenomenon, we would expect that once a mandate became law, those companies who could afford regular coverage and had insurable employee populations would immediately seek private coverage leaving the less healthy risks to buy coverage through the pool. Because the bill has a two year phase-in, there would be ample time for this to happen. This absence of the better risks would result in much higher benefit costs in the pool, and as a result higher premiums for those enrolled.

Additional Proposals

Because we are concerned about potential undesirable side effects of the proposed mandate, I would like to offer some recommendations which also would take us toward the same goals as S. 1265. We believe that, with these changes our Blue Cross and Blue Shield Plans and employers could work together to solve much of the uninsured problem.

Medicaid

Today's political and fiscal circumstances make it difficult to reach agreement on how to assist the low income, however, we believe that some Medicaid improvements are essential in improving assistance for the uninsured.

Congress has already started to expand assistance for the uninsured by supporting optional Medicaid coverage of pregnant women (prenatal, delivery and 60 days of postpartum care) and young children up to poverty levels. However, most of these reforms are still optional. We suggest that Congress make these recent optional expansions mandatory. Given the sharp regional variation in the uninsured problem, which is clearly related to varying Medicaid eligibility levels, we believe government should be looking at nationally uniform Medicaid eligibility standards.

A further reform would be for Medicaid to reexamine its responsibility to the full-time low income worker. Where benefits are not provided by an employer, we support allowing workers whose earnings are at or below the poverty level to buy into Medicaid with an income-related premium. In the situation where an employer offers coverage to the worker but not to family members, we support allowing dependents a similar option to purchase Medicaid.

Mandated Benefits

We support changing ERISA as you do to provide that insured health benefits are no longer subject to state mandated benefit laws. These mandates add to the cost of all insured health benefits, and small employers are disproportionately affected. We strongly believe that relief from these mandates will help make coverage more affordable to small employers and make it possible to tailor coverage to meet their needs.

Risk Pools for the Uninsured

While they do not directly affect the working uninsured, risk pools for the medically uninsurable may be appropriate in some states to assure access to health coverage. Risk pools are not necessary in every state; many Blue Cross and Blue Shield Plans accept all applicants regardless of medical condition. In the states where pools are operational, pool losses are shared only by those with insured health benefits because ERISA precludes states from requiring self-funded companies to contribute to pool losses. We believe such a limited funding base not only is inequitable but deprives the state pool of a substantial subsidy. We support the federal government changing ERISA so that self-funded companies will participate in state risk pools.

Tax Options

We also believe it is important for Congress to provide the same 100% tax deduction of health insurance premiums for unincorporated businesses, sole proprietorships and the self-employed as is permitted for corporations. We understand you already are considering this change and we believe this would help assure that these businesses have adequate health coverage.

In summary, Mr. Chairman, we share your conviction that the private and public sectors must build new partnerships to assure that every American has adequate health coverage. We are ready to work with this Committee and others to meet our common objectives.

Senator **Weicker**. Mr. Schramm.

Mr. **Schramm**. Thank you, Mr. Chairman.

Before I begin, I would like to say that I have been on the job for six weeks, and I have asked Karen Williams, the Director of our Research Department, to join me in case I need some help with some statistics.

Mr. Chairman, the Health Insurance Association of America is the trade association for 340 insurance companies which provide commercial insurance to roughly half of the health insurance-covered population in the United States.

Approximately 10 percent of our membership business comes from individuals, 40 percent from employers with less than 100 employees, and 50 percent from employers with more than 100 employees.

Mr. Chairman, our member companies are greatly concerned about those 35 to 37 million Americans who do not enjoy the protection of health insurance. As the new president of the association, I am pleased to report a commitment among our companies to work with government in developing effective methods to provide coverage to this population.

Historically, private insurance has provided coverage to millions of Americans. You heard Mr. Briggs talk earlier about at least 175 million people covered by private insurance today.

Our companies have worked hard in the past to develop creative solutions, often working with government both at the Federal and State level, to extend health care benefits to uninsured groups and individuals, some of whom constitute the uninsured population we are talking about today.

But the task of ensuring that all Americans enjoy the protection of insurance is difficult. We believe that mandating health insurance benefits through employment is not the appropriate way to approach this complex problem. The very nature of the composition of this group suggests a multitude of private and public solutions that must be considered. This complexity is largely a function of the uninsureds' heterogeneity. Approximately one-third of the uninsured are poor; another one-third are the near-poor, ranging between 100 and 200 percent of the Federal poverty level; and one-third are above the poverty ceiling, in excess of 200 percent of the poverty ceiling.

The uninsured are distributed across all types of family structures. While the majority are in some ways related to the work force as either a worker or dependent of a worker, most of these are poor and near poor.

Finally, uninsured workers and their families are concentrated among certain industries, retail, trade, and services, and are disproportionately represented among smaller establishments.

All of the above make any single solution difficult. We see the need to address the unique needs of various subpopulations among the 35 million uninsured with a series of solutions.

The commercial insurance industry is convinced that a multitude of approaches are necessary, and we would propose several today.

First, as regards high-risk uninsureds, we encourage the expansion of State-operated pools to encourage access to those who can afford private sector coverage but are currently denied coverage for health reasons.

Second, small businesses must be given greater incentive to provide coverage for their employees. Self-employed individuals should get a 100 percent deduction for their health insurance protection as long as they provide equal coverage to their employees, if any.

Third, the ERISA preemption of State-mandated benefit plans should be extended to insured employee plans as well as self-insured plans, allowing equity in the insurance marketplace. Insurers should have the flexibility to design less expensive benefit packages which would attract additional voluntary participation.

Fourth, Medicaid should be expanded to cover all persons otherwise eligible for Medicaid if their income is below the Federal poverty line.

Fifth, the near-poor, those below, say, 150 or 200 percent of the Federal poverty line, could be allowed to purchase Medicaid on an income-related and possibly subsidized basis if not covered by an employer plan.

As you can see, we believe that there is an appropriate private/public solution to the complex problems that make up the population of uninsured Americans. We believe it unwise and unnecessary to propose a system of employer-mandated insurance with a system of untried regional risk pools for the problem that confronts us. This proposal fails to meet the needs of at least 45 percent of the uncovered population. Turning to an employer-mandated system evades the failure to develop comprehensive and uniform coverage for the poor through Medicaid to meet the government's promise of coverage for those who we know from history are not easily or appropriately covered by private sector insurance.

The cost of the benefits proposed might actually hinder marginal employers in their search for insurance. And finally, there can be no evading the problem that by increasing the real wage cost of employers, employment displacement effects will result.

In closing, I would remind you that the private insurance system is built on the principle of risk selection. It is highly competitive. We have over 600 companies committed to selling insurance to an ever-larger number of Americans. But there are risks that the private system cannot underwrite, and mandating coverage will not change this fundamental reality.

Our member companies have committed themselves to working with each other in fashioning an industry solution to the problem of the uninsured—one that must involve government. I can assure you that we have several groups of the highest-level personnel in our companies developing proposals that, when taken together, will hopefully yield a comprehensive private and public approach to this problem. These proposals will contemplate the reality that health care coverage is both purchased by employers on behalf of large groups, as well as individuals buying single-coverage policies.

Our proposals will push the limits of our abilities to fashion effective private sector approaches. But finally, we will call on government to play a responsible role in providing financing for those originally envisioned as properly protected by government.

Thank you.

[The prepared statement of Mr. Schramm follows:]

Statement
# of the
HEALTH INSURANCE ASSOCIATION OF AMERICA
on
HEALTH INSURANCE COVERAGE AND THE SMALL EMPLOYER

Presented By

Carl J. Schramm, Ph.D., J.D.
President

Before the
Committee on Labor and Human Resources
United States Senate

June 24, 1987
Washington, D.C.

I am Carl J. Schramm, President of the Health Insurance Association of America. The HIAA is a trade association of 335 commercial insurance carriers who provide approximately 40 percent of the health insurance services in the United States. Approximately 10 percent of our membership business comes from individuals, 40 percent from employers with less than 100 employees, and 50 percent from employers with more than 100 employees.

Mr. Chairman, the HIAA is deeply concerned about the 35 million Americans who lack health insurance protection and we want to help solve the problem.

In America today, the vast majority of working citizens are covered by health insurance. The HIAA estimates that at the end of 1985, approximately 167 million persons under age 65, including spouses and children, were covered by one or more forms of private health protection.

Ninety percent of those privately covered receive benefits through their employer's group insurance, usually without individual medical underwriting. About 10 percent are covered by individual health insurance policies.

The widespread availability of private health insurance benefits has accomplished three things: (1) it has removed a significant source of economic uncertainty for families (ensuring greater worker productivity and overall well-being); (2) it has contributed directly to the improved health status of the American people; and (3) it has eliminated the need for the government to provide health care financing through increased taxation.

However, the fact that the vast majority of Americans under age 65 have private health protection is small comfort to those who go without.

But to solve the problem, it is necessary to first understand it. As more facts come to light, it is becoming clear that there is no one simple solution to the problem. The problem is as much one of poverty as it is lack of employer coverage.

Of the 35 million uninsured individuals, about thirty percent are full-time workers, that is, working 35 hours a week or more. An additional 30 percent are the uninsured spouses and children of these workers. Furthermore, these uninsured workers are predominately low wage earners; 75 percent have earnings below $10,000 a year. However, a third of all uninsured have family incomes below the federal poverty level; a third have family incomes between one and two times the poverty level; and a third have family incomes more than twice the federal poverty level. In short, the majority of the uninsured who do not have access to employer coverage, are too poor to comfortably purchase individual health insurance and are currently too rich to qualify for government health programs according to state standards.

Because of a number of concerns, the HIAA, at this point in time, essentially opposes a mandate on all employers to provide health insurance for their employees. We have long supported the expansion of employment-based health insurance coverage. However, we do know that mandating coverage has inherent problems of its own. The potential impact on employment and business failure rate, particularly for the very smallest employers, must be thoroughly understood before we pursue this course. Mandatory coverage will not close all existing gaps in coverage. However, there are steps that the HIAA does support that the Congress can and should take now to close existing gaps in coverage short of an employer mandate.

Because of the varied income levels and situations of the residual 35 million unprotected Americans, we propose a series of steps to enable, encourage, or provide protection.

First, to encourage unincorporated small businesses to provide coverage for their employees, self-employed individuals should get a 100% deduction for their health insurance protection as long as they provide equal coverage for their employees, if any.

Second, the ERISA pre-emption of state mandated benefit laws should be extended to insured employee health plans as well as self-insured plans. There are approximately six hundred state laws on the books mandating employee benefits. They range from the expensive--mental health benefits--to the exotic--acupuncture and Chinese medicine. Without contesting their individual merits, taken together they often provide a plan that is simply too rich for many small businesses to afford, so they buy nothing. Employers too small to self-insure should, above all, have the right with their employees to pick and choose which benefits best suit their circumstances if they can't afford them all. Insurers should have the flexibility to design less-expensive benefit packages which would attract voluntary participation.

Third, Medicaid should be expanded to cover all persons otherwise eligible for Medicaid if their income is below the Federal poverty level.

Fourth, the "near-poor", those below say 150% or 200% of the Federal poverty level and excluded from Medicaid either by income level or family structure, should be allowed to buy into Medicaid on an income-related subsidized basis if not covered by an employer plan.

Fifth, state pools for uninsurables, such as that recently enacted in Illinois, should be encouraged in all states, to guarantee access to uninsurable individuals who can afford health insurance but are currently denied coverage for health reasons.

An Employee Benefits Research Institute analysis of the 1985 Current Population Survey shows that among the 35 million uninsured:

18% are poor or near poor adults and children living in families without a full-time worker. HIAA recommends allowing poor and near poor individuals who are ineligible for Medicaid to "buy in" to Medicaid through payment of a premium.

10% are below poverty, nonworking and "categorically" eligible for Medicaid. HIAA recommends expanding Medicaid for categoricals up to 100% federal poverty level.

25% are poor or near poor full-time workers and their dependents. Those below poverty are excluded from Medicaid by lack of dependents. Those between 100-150% of poverty are excluded by income regardless of family structure. HIAA recommends a Medicaid buy-in for such individuals at premiums they can afford. This 25% could also be covered under employer mandated coverage.

9% are below poverty, full-time workers and their dependents who, except for either state income standards or federal limits on hours worked, would be "categorically" eligible. HIAA recommends expanding Medicaid for categoricals up to 100% of poverty. This 9% could be covered under employer mandated coverage as well.

23% are full-time workers and their dependents who are above 200% of the poverty level and who are not self-employed. HIAA has no specific policy solution for these individuals since they have sufficient income to purchase individual coverage. State pools for uninsurables guarantee access.

5% are the self-employed and their dependents with family incomes above 200% of the federal poverty level. HIAA recommends 100% tax deductibility of premiums, instead of 25%.

10% are nonworkers and their dependents who are above 200% poverty. HIAA has no specific policy solution for these individuals since they have sufficient income to purchase individual coverage.

Without specifically endorsing or opposing the concept of an employer mandate to provide health insurance, we believe any such legislation should, at a minimum:

(a) preserve the industry's ability to underwrite and risk classify;

(b) override ERISA;

(c) preserve a competitive health care financing delivery system;

(d) mandate only benefits that are affordable and allow maximum flexibility to employers and unions to creatively expand benefits;

(e) be easy to administer.

The HIAA is certainly willing and anxious to work with the Committee to devise acceptable ways to make the proposed legislation meet these criteria.

We do have a number of specific problems with the bill as it stands.

(1) The level of benefits are too high to be affordable to marginal employers and should be reduced.

(2) The required level of employer contribution exceeds industry norms and may further effect the marginal employer ability to afford the benefits.

(3) The provision relative to part-time employees is probably too liberal.

(4) The Coordination of Benefits provision tends to separate family units, making administration more costly and benefit plans more confusing.

(5) The particular pooling approach suggested is fraught with problems. It not only fails to recognize the need for proper risk selection, but it also tends to exclude small insurers from the market.

I would like to amplify this last point, since the exclusive regional pooling mechanism in S. 1265 would drive many insurers now selling small group insurance out of the marketplace.

The commercial insurance industry is a private system built on the fundamental principle of risk selection. It is a highly competitive industry with over 600 companies writing health insurance benefits. The result of this competition is that a large number of Americans are able to purchase health insurance at very low costs. However, we recognize that risk selection inevitably results in some who cannot obtain health protection; therefore, there has to be a residual mechanism for people to obtain insurance.

There are a number of other approaches to the problem that need to be studied and considered, including reinsurance and the extension of state risk pools for uninsurables which The HIAA has long endorsed. We are working on these alternatives and want to share our results and conclusions with the Committee as they became available.

In summary, we feel:

- The Committee should move cautiously and keep in mind the impact on employment and the need to preserve a legitimate role of management in determining benefit patterns and to preserve the insurance industry's right to properly assess and price risk;

- A comprehensive solution to the problem would go beyond mandates to include:

  (a) tax incentives for the self employed;
  (b) uninsurable risk pools;
  (c) Medicaid expansion and reform; and
  (d) pre-emption of state mandatory benefit laws.

Senator **Mikulski** [presiding]. Thank you, Dr. Schramm, for your testimony.

I understand that HIAA neither supports nor opposes the legislation at this time.

Dr. **Schramm**. Senator, we in fact are very concerned about many aspects of the legislation, and at this time we essentially oppose the legislation.

Senator **Mikulski**. I have a question both for you and Mr. Tresnowski. Each one of you represent, really, the main providers of private sector insurance profitmaking and not-for-profit.

First of all, I think we would all agree that health care provision or insurance for that population which is not uninsured is a desirable goal. It is not only a desirable goal for those who are at risk, but also for those institutions that provide a tremendous amount of the uncompensated care—something that I know you have been an expert in, Dr. Schramm.

How, then, can we meet the social need and yet exercise fiscal responsibility and work with the private sector?

Do you think members of HIAA could fashion a no-frills, basic health insurance policy that could be affordable for private sector firms that now cannot do this and therefore come up with different types of recommendations for a bill?

Dr. Schramm—what we are looking for is solutions on how we can deal with the issue of uncompensated care and people at risk. This Senator is not wedded to a particular bill: I am focused on an outcome.

Dr. **Schramm**. Senator, I think that is the way to travel, keeping our eye on what outcome we want to accomplish. One of the most attractive parts of this legislation is in fact the assault on State mandated benefits. These mandates often result in pushing up the cost of health plans underwritten by our companies. One of the things that we are exploring as we attempt to reach, I think, the same solution in terms of insuring a larger portion of this population, is in your terms, a stripped down plan, offering coverage of basic benefits.

Senator **Mikulski**. What about you, Mr. Tresnowski?

Mr. **Tresnowski**. Senator Mikulski, it is always hazardous to oversimplify a very complex matter, but lets do it just for purposes of answering your question.

What is intended here as a target population? There has been a lot of discussion here this morning about who that population is, but general consensus is that these are the low-income full-time worker—24 million, whatever it amounts to.

And there are two parts to the solution to that problem. One part is how do you pay for it. This bill proposes one; other ideas include tax credits; others talk about a medicaid buy-in, and on and on and on.

Your question focuses on the second part, and that is, once you have found the money, how do you buy the coverage in an insurance market that is as flawed as I said that it is a moment ago.

Years ago, the Blue Cross/Blue Shield plans, and in some communities still existing, provided health coverage at so-called community rates; in other words, there was a large risk pool, and there was a single rate provided for everybody in that risk pool.

The intensity of competition, the market segmentation, and all of those things that have gone on have made that opportunity much less viable than it is today—thus, the problem as it presents itself here.

The key question is, How can you restore a community rate. The answer is not, in our opinion, with regional pools as suggested in this legislation. We do not know what the answer is, but perhaps it is on a State basis, and perhaps the way to do that is to select carriers like we have done with Senator Baucus' certification requirements under medigap—some kind of a thinking through of how to restore a community rating on a geographic basis which retains the competitiveness of the marketplace in order to discipline the marketplace.

We are working on those questions, and we would hope to supply our views to the Committee at a subsequent date.

Senator **Mikulski**. Did you want to add to that, Dr. Schramm?

Dr. **Schramm**. No, Senator.

Senator **Mikulski**. Well, you see, Mr. Tresnowski, I actually believe we do pay for it. It is not where do we find the money; it is that we now have cost-shifting of providing care. It is not that care is not being provided. I believe it is being provided inappropriately at acute care facilities because of the absence of health insurance. The working poor make excessive use of emergency rooms, which is the most expensive place that you can go to for care. And usually by that time the situation is probably acute. That means that acute care facilities assume the burden for that.

Now, for those of us like in Maryland, where we have all-payer hospital cost containment programs, which Dr. Schramm helped be the architect of, working with many of us, we had a way of dealing with that. But right now, what I find in many States—and we had one of the nuns who heads up the Catholic Hospital Association talk about the burden that is being faced by Catholic hospitals providing what we would call the "charity cases"—so that cost is being borne already, and essentially what we have done is just shift that responsibility.

Now, it is true, it is not the same pool of money, but the burden is being born. It is not like care or no care. And I think maybe it is even costing us more. That is why we are trying to see what kinds of methods we could have to deal with this.

I still support hospital cost containment using all-payer systems. I know Senator Kennedy and I and Dick Gephardt believed in a national hospital cost containment program that would set Federal standards and let States develop their own methodologies, encouraging all-payer systems. We do not think there is the climate now for that. So this is one of the areas that we are looking at.

We would welcome any of your thoughts.

Mr. **Tresnowski**. Senator Mikulski, I would be the last person in the world to defend the current system of financing through uncompensated care and the other vehicles that are in place today. They are not only inefficient, but they are counterproductive to the health of the population. It needs to be changed. The question is how do you change the financing structure.

This particular bill says that we will put that responsibility on the employer. And my point is that maybe there is a combination of approaches, through Federal tax credits, through State Medicaid programs by making more uniform the eligibility standards, requiring the options for the pregnant woman and the poor child, getting the State involved in addition to placing a burden on the employer, and on the employee to help finance it.

The point that I was simply making is that we need some creative thinking along those lines. There are opportunities, and I outlined them in my testimony. But clearly, I want to be on the record as saying that changes are necessary.

Senator MIKULSKI. Well, Dr. Schramm and Mr. Tresnowski, the Committee would welcome your further comments and proposals on this, ranging from the use of tax credits, the extension of Medicaid, the concept of a no-frills package that perhaps the insurance community could provide at minimum cost and also the type of techniques that would deal with overutilization, inappropriate utilization, the kinds of things that I know labor and management have already talked about in employment, where there are unions to deal with.

Dr. SCHRAMM. Senator, as you know, I am relatively new to this post, and I have been very pleased, as I reported a few minutes ago——

Senator MIKULSKI. I know, and that is why I think your testimony was this short; it was great.

Dr. SCHRAMM. And that is why Karen Williams is here to keep me out of deep trouble.

I have been very pleased to see the level of interest in this proposal and the level of commitment, I must say, from all levels of our companies including the very highest. I have talked to many chief executives in the last few weeks about this proposal. I think there is a genuine commitment to working with government in order to deal with the problem that has to be solved: that is the growing number of people without insurance.

I think our own joint experience in Maryland is really very helpful, and may be not well-understood by people from other jurisdictions. One of the great accomplishments in Maryland was that people were protected on an individual basis, which is to say we beat the cost-shift problem to a great extent. One of the ways we accomplished that was because there was responsible behavior by all the parties that in fact had responsibility for health finance, including Medicaid, in the State of Maryland. Medicaid stepped up, it paid its fair share. Medicare, under the waiver paid its fair share. And I am happy to report history will show that the Health Insurance Association was instrumental in passing the initial legislation in the State of Maryland.

In that situation, individuals were the protected focus of insurance, and employer mandates would not necessarily ever emerge in the State of Maryland. I think that is very instructive as to what the problem is, and it suggests the solution.

I think one of the things that we have articulated as a potential solution here today, and I think probably more vocally than any other witness this morning, is a sense of enlargement and commitment from the government to renew its commitment to those parts of the population that will never be attractive, either because of lack of a nexus with the labor market for the most part, or because they are in marginal employment and will never be reached by either Blue Cross or commercial insurance. And we have known that to be a problem for 30 or 40 years. Attempting to cure this problem immediately to the untried concept of risk pools for employers, strikes me as a very precipitous move. This is indeed, as has been observed, landmark legislation, legislation where we have to go, I think, very cautiously, carefully, with all the parties dedicated to working on a solution to this genuine, real problem.

Senator MIKULSKI. Very good.

We thank you for your testimony, and I know, speaking for Senator Kennedy, who had to leave, we welcome further advice from you.

We now move to our last panel, with some of the groups we are most concerned with—small business.

Frank Carroll is President of the Small Business Service Bureau, one of the most important and knowledgeable people in the country on small business.

Alice Griffin is the Chair of the Smaller Business Association of New England.

Frank Swain is the Chief Counsel for Advocacy of the Small Business Administration.

Mr. Carroll, my briefing material tells me you are one of the most knowledgeable people in this country about the insurance needs of small business. Let us hear what you have to say.

STATEMENT OF FRANCIS R. CARROLL, PRESIDENT, THE SMALL BUSINESS SERVICE BUREAU, INC., WORCESTER, MA; ALICE GRIFFIN, PRESIDENT, GRIFFIN PENSION SERVICES, INC., SOUTH HAMILTON, MA, ON BEHALF OF SMALLER BUSINESS ASSOCIATION OF NEW ENGLAND; AND HON. FRANK S. SWAIN, CHIEF COUNSEL FOR ADVOCACY, U.S. SMALL BUSINESS ADMINISTRATION, WASHINGTON, DC

Mr. CARROLL. Thank you very much.

I appreciate the opportunity to address you on the impact that mandated health insurance would have on small business.

As you know, Small Business Service Bureau is an organization of over 35,000 small businesses across the country.

Senator MIKULSKI. Mr. Carroll, would you pull that microphone closer to you? There is always a bit of a buzz in this room. We want you to be heard, and we do not want you to shout, because you are going out on C-SPAN right this minute—you, in lieu of Ollie North.

Mr. CARROLL. We are an organization of over 35,000 small businesses, Senator. The three purposes of SBSB are: legislative advocacy; management assistance programs, like how to start your own business, how to do business in China. And one of the most important benefits that we offer very small businesspeople is group health insurance such as HMOs or many Blue Cross programs, particularly those small employers who cannot buy it.

I am also a member of the United States Senate's Small Business Committee's Advisory Council and the SBA's National Advisory Council.

SBSB has been involved with health care issues for nearly 20 years. Through numerous ballot surveys of our members, both by what we call a ballot where they vote, and by surveys, we found that the availability and the affordability of health insurance has consistently been their primary concern. Even though the "mom and pop" business and self-employed individuals—and these are the kinds of people who make up the bulk of the SBSB membership—usually oppose government regulations, our ballot surveys show that overwhelmingly, they favor government regulation to reduce the cost of health care. We believe that S. 1265 provides them with the type of protection they are looking for.

It is not bureaucratic. It is not a mandate for socialized medicine. Instead, it builds on the strength of America's private sector health insurance system.

This bill is an important step toward making health insurance affordable for small business owners and their employees. Our members are tired of paying the exorbitant premiums and being denied adequate access to quality health care for themselves, their employees, and their families.

High costs are bad enough. Many American workers, and particularly those who are self-employed, cannot get health insurance at any price. Many of America's small business owners and their employees cannot pass a health statement. Some have a history of health problems. Others are discriminated against because of their age, even though they may be only 50 years old. Still others are denied health insurance because of their spouse or their children who may have health problems.

I will bet my right arm, Senator, that many people in this room could not pass a group health statement today if they had to.

We at the Small Business Service Bureau applaud this bill because we feel it will lower the cost of health insurance premiums for small business owners and their employees.

We applaud this bill because it establishes community-rated pools without pre-existing condition exclusions.

We applaud this bill because of its managed care provisions.

We applaud this bill because it will provide access to health insurance for small businesses and their employees. And we must remember—a large portion of the estimated 37 million uninsured Americans are small business owners, employees and dependents.

Under Senate 1265, no longer will small businesspeople have to go without coverage because of poor health.

Let me share a couple of examples of the type of problem this bill will solve.

Last week, one of our members, a small businesswoman in North Carolina, applied for group health coverage for her family. Because her 13-year-old son has a heart defect, her application in all likelihood will be denied.

Another first-hand example. A healthy woman gave birth to premature twins. Her medical bills exceeded $200,000. Now, if she had experience-rated coverage, there would have been a substantial possible rate increase for everyone in the group. Because she was enrolled in an HMO, she had community-rated coverage, and her medical costs were absorbed by everyone in the HMO. There was no impact on rates. That is why the community rating provision of this bill is so important.

Senator MIKULSKI. Mr. Carroll, we have a wonderful timekeeper, because the Senate will convene at 2 o'clock. That is a signal that your time is going to be up.

But I think your example is well-taken. Could you move into, I think, the corrections. I think you said why you like it, that it is not bureaucratic, and then I think you have some suggestions.

And by the way, your entire statement will be in the record. But let us have you say now those constructive suggestions you would like to make, and then we will come back.

Mr. CARROLL. OK. The bill requires that employers pick up the entire cost of health insurance for employees, for example, earning less than $4.19 an hour.

Our studies show that employees who contribute nothing to their insurance premiums do not treat the benefit the same as those who contribute do. By forcing small business owners to pay 100 percent, we think it would be costly and could push some of the struggling businesses over the brink. The Federal Government, for example, as you know, Senator, only pays 75 percent.

So we propose that employees, for example, in terms of the number of hours of part-time work, should be increased to 20 hours.

We like the idea that nonprofits and municipalities will comply; we are pushing very hard for Senator Bumpers' bill, S. 1370. For example, regardless of the fate of this legislation, Senator, we strongly urge the Congress to enact Senator Bumpers' bill, S. 1370, that would allow self-employed individuals to deduct up to 80 percent of their health insurance premiums. And this is a good step toward equality with big companies, so we think that is necessary.

We like Senator Weicker and Senator Kennedy's companion proposals of 100 percent deductible for health insurance premiums. That is important. But I think Senator Bumpers is absolutely on the right track. The community-rated regions, in our opinion, are absolutely a must, but we also feel that new business start-ups—and we have had a lot of experience in this area—it usually takes five years for them to get their feet on the ground, and we would like to see that extended in terms of giving them a chance to start their business.

With tax credits and tax deductibility, in my opinion, you reduce the difficulties for new business start-ups.

Senator MIKULSKI. On page 7 of your statement, you list a number of items stating why you support this bill.

Mr. CARROLL. Yes, Senator.

Senator MIKULSKI. Would you just go down that, and that closing example? I think that will give us a good picture. Then we will go on to Ms. Griffin.

Mr. CARROLL. All right. We enthusiastically support the bill because we like the idea that nonprofits and municipalities will have to comply. We like the flexibility of the actuarial equivalency provision. We like the idea of community-rated pools with no preexisting condition exemptions. In our case, we do believe that is manageable, Senator.

We like the idea that something is being done to make health insurance accessible to everyone. And I give the example of somebody 55 years old, frankly, from the State of Maryland, who is paying $770.56 a month for comprehensive group health coverage. That is $9,246.72 per year for group health insurance in your own State, Senator. We think that is exorbitant.

Senator MIKULSKI. Thank you very much, Mr. Carroll.

[The prepared statement of Mr. Carroll follows:]

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TESTIMONY OF

FRANCIS R. CARROLL

PRESIDENT

SMALL BUSINESS SERVICE BUREAU, INC.

BEFORE THE

UNITED STATES SENATE COMMITTEE ON

LABOR AND HUMAN RESOURCES

SUBCOMMITEE ON HEALTH

JUNE 24, 1987

The Small Business Service Bureau, Inc. (SBSB) is a national membership association for small businesses. SBSB provides its members with management assistance, legislative advocacy and group benefits and services.

MR. CHAIRMAN ... COMMITTEE MEMBERS ... THANK YOU FOR THE OPPORTUNITY TO ADDRESS YOU ON THE IMPACT THAT MANDATED HEALTH INSURANCE WOULD HAVE ON SMALL BUSINESS. MY NAME IS FRANCIS R. CARROLL. I AM PRESIDENT OF THE SMALL BUSINESS SERVICE BUREAU INC., A SMALL-BUSINESS MEMBERSHIP ORGANIZATION REPRESENTING MORE THAN 35,000 SMALL BUSINESSES ACROSS THE COUNTRY. I ALSO AM A MEMBER OF THE U.S. SENATE SMALL BUSINESS COMMITTEE'S ADVISORY COUNCIL AND THE U.S. SMALL BUSINESS ADMINISTRATION'S NATIONAL ADVISORY COUNCIL. SBSB HAS BEEN INVOLVED WITH HEALTH CARE ISSUES FOR NEARLY 20 YEARS. THROUGH NUMEROUS BALLOT SURVEYS OF OUR MEMBERS, WE'VE FOUND THAT THE AVAILABILITY AND AFFORDABILITY OF HEALTH INSURANCE HAS CONSISTENTLY BEEN THEIR PRIMARY CONCERN.

EVEN THOUGH THE "MOM AND POP" BUSINESSES AND SELF-EMPLOYED INDIVIDUALS WHO MAKE UP THE BULK OF OUR MEMBERSHIP USUALLY OPPOSE GOVERNMENT REGULATION, OUR BALLOT SURVEYS SHOW THAT THEY OVERWHELMINGLY FAVOR GOVERNMENT REGULATION TO REDUCE THE COST OF HEALTH CARE. WE BELIEVE S.1265 PROVIDES THEM WITH THE TYPE OF PROTECTION THEY'RE LOOKING FOR.

IT IS NOT BUREAUCRATIC.

IT IS NOT A MANDATE FOR SOCIALIZED MEDICINE.

INSTEAD, IT BUILDS ON THE STRENGTH OF AMERICA'S PRIVATE-SECTOR HEALTH INSURANCE SYSTEM. THIS BILL IS AN IMPORTANT STEP TOWARD MAKING HEALTH INSURANCE AFFORDABLE FOR SMALL BUSINESS OWNERS AND THEIR EMPLOYEES. OUR MEMBERS ARE TIRED OF PAYING EXORBITANT PREMIUMS AND BEING DENIED ADEQUATE ACCESS TO QUALITY

HEALTH CARE FOR THEMSELVES, THEIR EMPLOYEES AND THEIR FAMILIES.

HIGH COSTS ARE BAD ENOUGH. MANY AMERICAN WORKERS -- AND PARTICULARLY THOSE WHO ARE SELF-EMPLOYED -- CAN'T GET HEALTH INSURANCE AT ANY PRICE. MANY OF AMERICA'S SMALL BUSINESS OWNERS AND THEIR EMPLOYEES CAN'T PASS A HEALTH STATEMENT. SOME HAVE A HISTORY OF HEALTH PROBLEMS. OTHERS ARE DISCRIMINATED AGAINST BECAUSE OF THEIR AGE -- EVEN THOUGH THEY MAY BE ONLY 50 YEARS OLD. STILL OTHERS ARE DENIED HEALTH INSURANCE BECAUSE THEIR SPOUSES OR CHILDREN HAVE HEALTH PROBLEMS. I'D BET MY RIGHT ARM THAT MANY OF YOU HERE TODAY COULDN'T QUALIFY FOR GROUP HEALTH INSURANCE.

WE AT THE SMALL BUSINESS SERVICE BUREAU APPLAUD THIS BILL BECAUSE IT WILL LOWER THE COST OF HEALTH INSURANCE PREMIUMS FOR SMALL BUSINESS OWNERS AND THEIR EMPLOYEES.

WE APPLAUD THIS BILL BECAUSE IT ESTABLISHES COMMUNITY-RATED INSURANCE POOLS WITHOUT PRE-EXISTING CONDITION EXCLUSIONS.

WE APPLAUD THIS BILL BECAUSE OF ITS MANAGED-CARE PROVISIONS.

AND WE APPLAUD THIS BILL BECAUSE IT WILL PROVIDE ACCESS TO HEALTH INSURANCE FOR SMALL BUSINESSES AND THEIR EMPLOYEES. REMEMBER -- A LARGE PORTION OF THE ESTIMATED 37 MILLION UNINSURED AMERICANS ARE SMALL BUSINESS OWNERS, EMPLOYEES AND DEPENDENTS. UNDER S.1265, NO LONGER WILL SMALL BUSINESSPEOPLE HAVE TO GO WITHOUT COVERAGE BECAUSE OF POOR HEALTH.

LET ME SHARE A COUPLE OF EXAMPLES OF THE TYPE OF PROBLEM THIS BILL WOULD SOLVE. LAST WEEK, ONE OF OUR MEMBERS -- A SMALL BUSINESSWOMAN IN NORTH CAROLINA -- APPLIED FOR GROUP HEALTH

COVERAGE FOR HER FAMILY. BECAUSE HER 13-YEAR-OLD SON HAS A HEART DEFECT, HER APPLICATION IN ALL LIKELIHOOD WILL BE DENIED.

HERE'S ANOTHER FIRSTHAND EXAMPLE. WE RECENTLY HAD A HEALTHY YOUNG WOMAN EMPLOYED AT SBSB GIVE BIRTH TO PREMATURE TWINS. HER MEDICAL BILLS EXCEEDED $200,000. IF SHE HAD EXPERIENCE-RATED COVERAGE, THERE WOULD HAVE BEEN A SUBSTANTIAL RATE INCREASE FOR EVERYONE IN OUR GROUP. BECAUSE SHE WAS ENROLLED IN AN HMO, SHE HAD COMMUNITY-RATED COVERAGE AND HER MEDICAL COSTS WERE ABSORBED BY THE EVERYONE IN THE HMO. THERE WAS NO IMPACT ON RATES.

THAT'S WHY THE COMMUNITY-RATING PROVISION OF THIS BILL IS SO IMPORTANT. THIS PROVISION CERTAINLY ADDRESSES THE ISSUE OF ACCESSIBILITY, BUT WE'RE ALSO WORRIED ABOUT AFFORDABILITY.

WE STRONGLY BELIEVE THE COSTS SHOULD BE SHARED BY THE FEDERAL GOVERNMENT THROUGH TAX INCENTIVES, BY EMPLOYERS AND EMPLOYEES THROUGH COST SHARING, AND BY INSURANCE PROVIDERS THROUGH RISK CONTRACTS. INSURANCE PROVIDERS HAVE THE MOST TO GAIN FROM THIS LEGISLATION AND CAN AFFORD THE COST MORE EASILY THAN A SMALL BUSINESSPERSON.

LET'S TALK ABOUT WHAT THIS LEGISLATION WOULD DO. WHILE IT WOULD MAKE INSURANCE MORE AFFORDABLE FOR THOSE SMALL BUSINESSES THAT ALREADY CARRY HEALTH INSURANCE, IT COULD PUSH MANY UNINSURED SMALL BUSINESSES OVER THE BRINK. IN A NEW SBA STUDY, 67 PERCENT OF BUSINESS OWNERS WHO DO NOT OFFER HEALTH INSURANCE CITED INSUFFICIENT PROFITS AS THE REASON. THEY WOULD LIKE TO OFFER HEALTH INSURANCE -- THEY JUST CAN'T AFFORD IT!

THE PROPOSED LEGISLATION TYPICALLY WOULD COST AN EMPLOYER

$1,000 PER EMPLOYEE. THAT MAY NOT SOUND LIKE A LOT OF MONEY, BUT LET'S PUT IT IN ITS PROPER PERSPECTIVE. FORTY SEVEN PERCENT OF AMERICA'S UNINSURED WORKERS -- OR NEARLY 9 MILLION PEOPLE -- WORK FOR COMPANIES THAT EMPLOY FEWER THAN 25 PEOPLE. MANY OF THE UNINSURED ARE SOLE PROPRIETORS. THESE BUSINESSES TYPICALLY OPERATE ON THE THINNEST OF PROFIT MARGINS. ONE STUDY SHOWS THAT 80 PERCENT OF AMERICA'S PROPRIETORSHIPS HAVE ANNUAL SALES OF LESS THAN $50,000 A YEAR. ADDING $1,000 PER EMPLOYEE TO THE OPERATING EXPENSES OF THESE BUSINESSES WOULD BE THE EQUIVALENT OF ADDING A FINANCIAL BURDEN OF $2 BILLION TO GENERAL MOTORS. CAN YOU IMAGINE HOW GENERAL MOTORS WOULD REACT IF CONGRESS PASSED A LAW THAT WOULD COST GM $2 BILLION A YEAR?

BUT THESE FOLKS ARE NOT GM. THESE BUSINESSES UNDERSTAND THE IMPORTANCE OF OFFERING HEALTH CARE. THEY JUST WANT TO MAKE CERTAIN THEY AREN'T BURDENED WITH A COST THEY CAN'T AFFORD TO PAY. BECAUSE THE COSTS OF ADMINISTERING GROUP HEALTH COVERAGE ARE HIGHER FOR SMALL BUSINESSES, AND BECAUSE THEIR UNDERWRITING RISKS ARE HIGHER, SMALL BUSINESS OWNERS ALREADY PAY AS MUCH AS 200 PERCENT MORE PER EMPLOYEE FOR COVERAGE THAN LARGE COMPANIES.

WITH ONLY MINOR CHANGES TO S.1265, THE IMPACT ON SMALL BUSINESSES CAN BE LESSENED. FIRST, OWNERS OF UNINCORPORATED SMALL BUSINESSES SHOULD BE ALLOWED TO DEDUCT THE ENTIRE COST OF HEALTH INSURANCE, JUST AS LARGE COMPANIES DO. SENATOR KENNEDY HAS INTRODUCED COMPANION LEGISLATION COSPONSORED BY SENATOR WEICKER THAT WOULD ALLOW UNINCORPORATED, SELF-EMPLOYED BUSINESSPEOPLE TO DEDUCT UP TO 100 PERCENT OF THEIR HEALTH INSURANCE PREMIUM COSTS, PROPORTIONATE TO THE PERCENTAGE OF THE PREMIUM COSTS THEY PAY FOR THEIR EMPLOYEES. THIS COMPANION LEGISLATION HAS OUR WHOLEHEARTED ENDORSEMENT. IT IS THE SINGLE MOST IMPORTANT ACTION THAT CAN BE TAKEN TO MAKE MANDATED HEALTH INSURANCE AFFORDABLE TO AMERICA'S UNINSURED SMALL BUSINESSES AND THEIR EMPLOYEES.

MAKING THE PREMIUMS DEDUCTIBLE CERTAINLY WOULD LESSEN THE IMPACT OF THE FINANCIAL RESPONSIBILITY BORNE BY THE EMPLOYER. WE WOULD SUGGEST, THOUGH, THAT AN ADDITIONAL STEP BE TAKEN. BECAUSE OF THE ADMINISTRATIVE BURDENS THAT WOULD BE PLACED ON SMALL BUSINESSES AS THEY PHASE IN MANDATED HEALTH INSURANCE, SMALL BUSINESSES SHOULD TEMPORARILY RECEIVE A TAX CREDIT. A TAX CREDIT, COMBINED WITH DEDUCTIBILITY OF PREMIUMS, WOULD MAKE MANDATED HEALTH INSURANCE AFFORDABLE FOR ALMOST EVERY BUSINESS.

I SAY ALMOST EVERY BUSINESS, BECAUSE SPECIAL CONSIDERATION STILL MUST BE GIVEN TO START-UP COMPANIES. I UNDERSTAND THAT THIS BILL WILL EXEMPT COMPANIES LESS THAN TWO YEARS OLD WITH FEWER THAN 10 EMPLOYEES, EXCEPT FOR THE REQUIREMENT THAT THEY PROVIDE MINIMUM CATASTROPHIC COVERAGE. WE AT SBSB STRONGLY ENDORSE THIS CONCEPT. BUT WE BELIEVE IT SHOULD GO FURTHER. THE AVERAGE SMALL COMPANY HAS A START-UP PERIOD OF FIVE YEARS. IT TAKES THAT LONG FOR MOST COMPANIES TO BECOME WELL ESTABLISHED AND PROFITABLE. TO BURDEN AMERICA'S YOUNGEST BUSINESSES IN THEIR FORMATIVE YEARS BY REQUIRING THEM TO PAY FOR HEALTH INSURANCE WOULD HAVE A DETRIMENTAL ECONOMIC IMPACT THAT WOULD HURT THE FUTURE GROWTH POTENTIAL OF START-UP COMPANIES. KEEP IN MIND THAT AMERICA'S SMALLEST COMPANIES HAVE CREATED MOST OF THE COUNTRY'S JOBS IN

RECENT YEARS. FIRMS WITH FEWER THAN 20 EMPLOYEES HAVE ALONE CREATED ABOUT ONE-THIRD OF THE NEW JOBS IN THIS COUNTRY DURING THE PAST 10 YEARS.

WE HAVE SEVERAL OTHER CONSTRUCTIVE SUGGESTIONS DESIGNED TO PROTECT AMERICA'S ENTREPRENEURS WHILE AT THE SAME TIME PROVIDING HELP FOR THE WORKING UNINSURED AND UNDERINSURED.

1.) IN ADDITION TO S.1265, CONGRESS SHOULD CONSIDER S.218, SPONSORED BY SENATOR BUMPERS. S.218 WOULD REQUIRE AN ECONOMIC IMPACT STUDY FOR ANY NEW MANDATED BENEFIT. WE KNOW YOU SHARE OUR CONCERN ABOUT THE IMPACT MANDATED HEALTH INSURANCE WILL HAVE ON SMALL BUSINESSES. THAT'S WHY SENATOR BUMPER'S BILL DESERVES CONSIDERATION. I AM CONFIDENT THAT AN ECONOMIC IMPACT STUDY OF S.1265 WILL CONFIRM ITS POSITIVE IMPACT ON SMALL BUSINESSES AND THEIR EMPLOYEES.

2.) THE BILL REQUIRES THAT EMPLOYERS PICK UP THE ENTIRE COST OF HEALTH INSURANCE FOR EMPLOYEES EARNING LESS THAN $4.19 AN HOUR. WE DISAGREE WITH THIS PROVISION FOR TWO REASONS. FIRST, STUDIES SHOW THAT EMPLOYEES WHO CONTRIBUTE NOTHING TO THEIR INSURANCE PREMIUMS DO NOT TREAT THE BENEFIT WITH THE SAME VALUE THOSE WHO CONTRIBUTE DO. AN EMPLOYEE WHO DOESN'T HAVE TO PAY ANYTHING FOR HEALTH INSURANCE IS LIKELY TO ABUSE THE BENEFIT, CONTRIBUTING TO ESCALATING HEALTH CARE COSTS.

SECOND, FORCING SMALL BUSINESS OWNERS TO PAY 100 PERCENT WOULD BE COSTLY AND COULD PUSH SOME STRUGGLING BUSINESSES OVER THE BRINK. THE FEDERAL GOVERNMENT DOESN'T PAY 100 PERCENT OF THE HEALTH INSURANCE PREMIUMS FOR ITS EMPLOYEES -- IT PAYS 75 PERCENT

OF THE AVERAGE OF THE FIVE LARGEST CARRIERS.

3.) AS WRITTEN, THE BILL WOULD REQUIRE EMPLOYERS TO PROVIDE HEALTH INSURANCE TO ANYONE WORKING 17 1/2 HOURS OR MORE A WEEK. WE PROPOSE THAT ONLY EMPLOYEES WHO WORK A MINIMUM OF 20 HOURS A WEEK BE COVERED.

WE AT SBSB ENTHUSIASTICALLY SUPPORT THIS BILL.

WE LIKE THE IDEA THAT NONPROFITS AND MUNICIPALITIES WILL HAVE TO COMPLY.

WE LIKE THE FLEXIBILITY OF THE ACTUARIAL EQUIVALENCY PROVISION.

WE LIKE THE IDEA OF COMMUNITY-RATED POOLS WITH NO PRE-EXISTING CONDITION EXEMPTIONS.

WE LIKE THE IDEA THAT SOMETHING IS BEING DONE TO MAKE HEALTH INSURANCE ACCESSIBLE TO EVERYONE.

LET ME CLOSE WITH ANOTHER EXAMPLE OF WHY THIS BILL SHOULD BECOME LAW. LADIES AND GENTLEMEN, WITHIN FIVE MILES OF WHERE YOU NOW SIT, SMALL BUSINESSPEOPLE OVER 55 YEARS OLD ARE PAYING A FAMILY RATE OF $770.56 A MONTH FOR COMPREHENSIVE GROUP HEALTH COVERAGE. THAT'S $9,246.72 A YEAR, WHICH IS MORE THAN MOST OF OUR UNINSURED AMERICANS EARN. HOW MANY OF YOU COULD AFFORD THAT COST?

BECAUSE IT PROVIDES COMMUNITY RATED POOLS, WE BELIEVE S.1265 WILL MAKE SUCH EXORBITANT PREMIUMS A THING OF THE PAST. THANK YOU.

Senator MIKULSKI. Now we would like to turn our attention to Ms. Alice Griffin, representing the Smaller Business Association of New England, based in Waltham, Massachusetts. Senator Kennedy asked me to give you a particularly warm hello, Ms. Griffin.

Please feel free to proceed, and your entire statement will be in the record, but you have about 5 to 7 minutes.

Ms. GRIFFIN. Thank you, Senator.

I would want to begin, Senator, by asking you to convey to Senator Kennedy our great appreciation for being able to be here and be part of this very informative hearing.

The Senator has been very generous with his time and with his staff's time to our organization, which is a New England-based organization, SBANE, the Smaller Business Association of New England, and I speak on behalf of those members today and also on behalf of the 30,000 members of National Small Business United.

Senator Kennedy and his staff, particularly David Nexon behind you, have been very, very helpful and generous in their time and in listening to what are the concerns of small business regarding a mandated benefit and particularly a mandated health insurance benefit.

I regret that some of the earlier people who testified this morning were unable to remain here to hear some of the positions of small business, because they implied from their experience and knowledge of small business, and I would have welcomed an opportunity as a small business owner myself to have perhaps corrected the record for them.

Regarding today's legislation that will provide minimum essential health care, it is a subject that has created enormous alarm and concern among the small business community. In fact, opposition to mandated benefits was the number two recommendation of the 1986 White House Conference on Small Business.

The small business community cannot fault the merits of insuring all Americans and providing health insurance coverage, but the small business community supports creative efforts by the private sector to identify and fulfill the needs of all of its employees.

There is a deep and abiding concern that government-mandated benefits could result in the demise of the small business sector as the Nation's job provider.

Small business understands the problem of 37 million people in the United States with no health insurance coverage. To provide coverage for the approximately 26 percent of these people who are in the work force would reduce that 37 million by a substantial amount.

The small business employer does not provide coverage for the following reasons—the first of those being a lack of incentive due to the discrimination in the tax code against unincorporated business; second being the underwriting which currently enables carriers to reject an entire small group for coverage when even one employee has a medical problem; and third, the limited participation by conventional and alternative carriers in the small group marketplace.

For those of us who presently provide health insurance protection, the legislation raises many worries of increased costs. Our areas of concern are the 30-day waiting period, or almost immediate coverage; the coverage of part-time workers working 17½ hours per week; the employer bearing the cost of 80 percent of the premiums for employees and their dependent coverage and 100 percent of the cost for employees earning the minimum wage; we are concerned about the expanding areas of coverage; mandating pools for employers with fewer than 25 employees; and sixth, the very serious penalties for noncompliance. There are many, many small employers who perhaps would not understand this legislation and the penalties are very, very serious.

As you know, small business is labor-intensive, and any government action that shackles and directs small enterprises to increase overhead and expense at an alarming rate will certainly result in fewer hirings.

The proposed legislation places the financial responsibility squarely on the employer, and we must speak out and say that all small firms cannot bear this burden. There simply is not the surplus or profits in many firms to bear this expense.

Small firms are very close to the reality of income and expense, and we understand that there can be no additional payroll costs imposed on our businesses that can be supported by current income. Consequently, we will have to raise the price of goods and services to the extent it can be supported in the marketplace. And we are fearful that traditionally, this has not been a successful exercise by small firms because they just simply cannot spread their costs over their small number of customers.

What is left, then, for us in small business is that we have to absorb these costs and determine what we can absorb by reducing current expenditures. Wages and other benefits will surely have to be reduced, as that is the only variable that exists in most small firm budgets.

One of our SBANE members has reviewed this proposed legislation, and he is a manufacturer with in excess of 200 employees. Many of his employees are not presently covered because they are part-time people. Many of them are part-time because they are handicapped and are only able to work a limited number of hours.

His expenses, he estimates, will increase by almost 300 percent. He customarily pays 50 percent of the premium for his employees. The requirement to extend that to 80 percent will surely be very, very costly for him. And incidentally, he chose to cover the costs of premium at that 50 percent rate because that was the rate that the local government in the town in which he operated paid for the insurance premiums for the town workers.

So there is an impact here at the local and city level, and our towns and municipalities would also be experiencing some increased costs, which surely will show up in the economy.

We do commend Senator Kennedy for focusing the discussion, and we assure you that in the small business area, we want to work for an efficient and effective resolution. But we do not feel that the resolution can be a burden that is borne only by the employer.

There are new efforts under way across the country for private foundations, the public sector, the health care professionals and the business community to work on solving this problem. Some of these projects are being provided with advance funding by the Robert

Wood Johnson Foundation. The effect of these new approaches cannot as yet be measured because they are in the very early stages of implementation. But we believe we should wait to benefit by some of the experience.

Their purpose is to demonstrate new public and private funding for the uninsured and new or improved service delivery arrangements which would increase access for the uninsured. They appear to be innovative and appropriate to the regions they service. And what we are already learning from these projects is that this is a broad, intricate and difficult problem.

We in business find a strict mandate to be a dangerous solution to the problem, and prefer to work toward a greater understanding of the need for coverage among small employers. Many of the newer businesses have not been provided with sufficient information on how and where to find affordable coverage. By extending coverage in a voluntary way, would avoid a serious economic disruption in the small business sector of our economy. The economic recovery of this country in the 1980's was largely driven by the rapid expansion of the small business sector. Its ability to create jobs relieved a critical unemployment problem, and we believe that Congress should display greater understanding of that marketplace and allow these new companies an opportunity to achieve a stronger posture without the threat of a regulated workplace.

The entire world looks to the small business miracle in this country. Having personally been a part of that miracle, I must express to you my opinion that as a Nation, we must preserve the opportunities that small business provides to the economically deprived, minorities, and to women.

And while we wait for more information from projects such as these 15 projects funded by the Robert Wood Johnson Foundation, we do see action which could begin immediately to relieve some of the problems of the uninsured. We commend Senator Kennedy for filing the legislation to expand the 25 percent tax of premium deduction for sole proprietors or unincorporated businesses to 100 percent of premium if catastrophic coverage is included in their health insurance plans, and we hope that Congress will enact that legislation rapidly and send it to President Reagan for his signature and rapid implementation.

I want to stress that small business is not refusing to protect their workers' health. We are willing to be part of the solution. But Congress must understand that to mandate this expense in its present form will place the small business sector of our economy in a nongrowth posture. We think that would be very damaging to the economy and to the Nation.

In the spirit of free enterprise and competition, we hope the resolution of health care coverage can be a coalition of efforts and voluntary.

Thank you.

Senator Mikulski. Thank you for your excellent testimony, Ms. Griffin.

[The prepared statement of Ms. Griffin follows:]

SBANE

SMALLER BUSINESS ASSOCIATION OF NEW ENGLAND, INC.

STATEMENT
OF
ALICE B. GRIFFIN
PRESIDENT
GRIFFIN PENSION SERVICES, INC.

CHAIRMAN
THE SMALLER BUSINESS ASSOCIATION OF NEW ENGLAND, INC. (SBANE)

AND MEMBER
EMPLOYEE BENEFITS COMMITTEE
NATIONAL SMALL BUSINESS UNITED

TESTIFYING ON
S. 1265
MANDATED MINIMUM ESSENTIAL HEALTH INSURANCE

BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
WASHINGTON, D.C.

WEDNESDAY, JUNE 24, 1987

69 HICKORY DRIVE • WALTHAM, MASSACHUSETTS, 02154 • (617) 890-9070

Mr. Chairman:

Thank you for this opportunity to review with you S.1265 legislation that will mandate health insurance for all employees. My name is Alice Griffin. I am the President of Griffin Pension Services, Inc., which is a service company located in Hamilton, MA with a staff of ten. We provide administrative services to more than 400 companies to assure their compliance with Federal laws regarding retirement benefits and to inform the employees of their benefits earned under these programs. I founded this business in 1979 so that I could achieve my full potential in the workplace and so that I could meet the new financial demands imposed on our family due to a changing economic world. I am also serving as Chairman of the Board of Directors of the Smaller Business Association of New England (SBANE), the nations oldest independent small business organizaiton whose members number more than 1,800 growing businesses. On behalf of the SBANE Membership, I want to acknowledge and thank you for the time you have afforded our members to express themselves regarding mandatory health legislation.

You may recall, I was among the delegation of small business representatives who first met with you on this legislation on February 18, 1987. In addition, we had the pleasure of meeting with your staff assistant, David Nexon, on April 17 and a representative group also met with you and Mr. Nexon to discuss this legislation at National Small Business United's Washington Presentation on May 20. We have since received background material

FROM MR. NEXON IN ADDITION TO THE MEETINGS, AND THIS HAS BEEN REVIEWED BY MANY OF THE KEY MEMBERS OF SBANE.

TODAY, ON BEHALF OF NSBU AND ITS 30,000 MEMBERS AND SBANE AS THE OLDEST REGIONAL ASSOCIATION FOR SMALL BUSINESS, MY COMMENTS WILL BE A REVIEW OF THIS LEGISLATION AND THE MANY CONCERNS WE HAVE REGARDING ITS DISPROPORTIONATE IMPACT ON SMALL BUSINESS.

BEFORE I EXPRESS THESE CONCERNS, I WANT TO ACKNOWLEDGE THE CLOSE WORKING RELATIONSHIP YOU HAVE HAD WITH SBANE AND THE SMALL BUSINESS COMMUNITY FOR SO MANY YEARS. IT WAS IN 1980 THAT YOU FORMED A SMALL BUSINESS TASK FORCE TO MEET REGULARLY WITH MEMBERS OF THIS ASSOCIATION AND HELP US ORGANIZE EFFECTIVELY TO REPRESENT THE NEEDS OF SMALL BUSINESS BEFORE CONGRESS. OUR CLOSE WORKING RELATIONSHIP HAS BEEN MUTUALLY BENEFICIAL AND LED TO SIGNIFICANT LEGISLATIVE VICTORIES THROUGH THE YEARS.

YOU HAVE BEEN A LEADING SMALL BUSINESS ADVOCATE ON MUCH OF THE MAJOR INITIATIVES BROUGHT ON BY THE 1980 CONFERENCE ON SMALL BUSINESS. YOUR HELP IN THE AREA OF DEREGULATION IN THE AIRLINE AND TRUCKING INDUSTRY, COUPLED WITH YOUR SUPPORT OF THE REGULATORY FLEXIBILITY ACT, HAS TAKEN A GREAT DEAL OF GOVERNMENTAL INTERFERENCE OFF THE BACKS OF SMALL BUSINESS. IN SUPPORTING THE SMALL BUSINESS INNOVATION RESEARCH ACT, YOU HAVE OPENED THE WAY FOR MILLIONS OF RESEARCH DOLLARS TO BE COMPETITIVELY PLACED WITHIN THE REACH OF SMALL BUSINESS, ENCOURAGING THE INVENTIVENESS AND CREATIVITY IN THIS VITAL SECTOR.

DURING THE PAST TWO YEARS YOU HAVE JOINED WITH SMALL BUSINESS ORGANIZATIONS TO OPPOSE THE ELIMINATION OF THE SMALL BUSINESS ADMINISTRATION, AS PROPOSED IN THE LAST TWO FISCAL YEAR BUDGETS. IN SUMMARY, MR. CHAIRMAN, YOUR TRACK RECORD ON BEHALF OF SMALL BUSINESS HAS BEEN POSITIVE AND NOTEWORTHY.

REGARDING TODAY'S LEGISLATION THAT WILL PROVIDE MINIMUM ESSENTIAL HEALTH CARE, IT IS A SUBJECT THAT HAS CREATED ENORMOUS ALARM AND CONCERN AMONG THE SMALL BUSINESS COMMUNITY. IN FACT, OPPOSITION TO MANDATED BENEFITS WAS THE NUMBER TWO RECOMMENDATION OF THE 1986 WHITE HOUSE CONFERENCE. THE SMALL BUSINESS COMMUNITY CANNOT FAULT THE MERITS OF INSURING ALL AMERICANS AND PROVIDING HEALTH INSURANCE COVERAGE. THE SMALL BUSINESS COMMUNITY SUPPORTS CREATIVE EFFORTS BY THE PRIVATE SECTOR TO IDENTIFY AND FULFILL THE NEEDS OF ITS EMPLOYEES. THERE IS DEEP AND ABIDING CONCERN THAT GOVERNMENT MANDATED EMPLOYEE BENEFITS COULD RESULT IN THE DEMISE OF THE SMALL BUSINESS SECTOR AS THE NATION'S JOB PROVIDER.

SMALL BUSINESS UNDERSTANDS THE PROBLEM OF 37 MILLION PEOPLE IN THE UNITED STATES WITH NO HEALTH INSURANCE COVERAGE. TWENTY-SIX PERCENT (26%) OF THESE UNINSURED ARE EMPLOYED IN SMALL FIRMS. (8.2 MILLION). TO PROVIDE COVERAGE FOR THEM WOULD REDUCE THE 37 MILLION BY A SUBSTANTIAL AMOUNT WHEN WE TAKE INTO CONSIDERATION THE DEPENDENTS OF THESE EMPLOYEES.

THE SMALL EMPLOYER DOES NOT PROVIDE COVERAGE FOR THE FOLLOWING REASONS: 1) LACK OF INCENTIVE DUE TO THE DISCRIMINATION IN THE TAX CODE AGAINST UNINCORPORATED BUSINESSES; 2) UNDERWRITING FACTORS

WHICH ENABLE CARRIERS TO REJECT AN ENTIRE SMALL GROUP FOR COVERAGE IF EVEN ONE EMPLOYEE HAS A MEDICAL PROBLEM, AND 3) LIMITED PARTICIPATION BY CONVENTIONAL AND ALTERNATIVE CARRIERS IN THE SMALL GROUP MARKETPLACE.

FOR THOSE OF US WHO PRESENTLY PROVIDE HEALTH INSURANCE PROTECTION, THE LEGISLATION RAISES MANY WORRIES OF INCREASED COSTS. OUR AREAS OF CONCERN ARE:

1) IMMEDIATE COVERAGE/NO WAITING PERIOD.
2) COVERAGE OF PART-TIME EMPLOYEES WORKING 17 1/2 HOURS PER WEEK.
3) EMPLOYER CARRYING THE COST OF 80% OF THE PREMIUMS FOR EMPLOYEE AND DEPENDENT COVERAGE.
4) EXPANDED AREAS OF COVERAGE.
5) MANDATED POOLS FOR EMPLOYERS WITH FEWER THAN 25 EMPLOYEES.

AS YOU KNOW, SMALL BUSINESSES ARE LABOR INTENSIVE. ANY GOVERNMENT ACTION THAT SHACKLES AND DIRECTS SMALL ENTERPRISES TO INCREASE OVERHEAD AND EXPENSE AT AN ALARMING RATE WILL CERTAINLY RESULT IN FEWER HIRINGS.

THE PROPOSED LEGISLATION PLACES THE FINANCIAL RESPONSIBILITY SQUARELY ON THE EMPLOYER. WE MUST SPEAK OUT AND SAY THAT ALL SMALL FIRMS CANNOT BEAR THIS BURDEN. THERE SIMPLY IS NOT THE SURPLUS OR PROFITS IN MANY FIRMS TO BEAR THIS EXPENSE.

IN THE COURSE OF THE BUSINESS DAY I SPEAK WITH MANY OWNERS OF SMALL

FIRMS, EITHER AS CLIENTS OR AS COLLEAGUES IN SBANE. A PERSISTENT THEME IN THESE CONVERSATIONS IS THE COST OF DOING BUSINESS. THE SMALL EMPLOYER ALREADY FACES HIGH MANDATORY PAYROLL EXPENSES WITH THE COST OF SOCIAL SECURITY TAXES (7.5% IN 1988) AND UNEMPLOYMENT TAXES. ADD TO THAT THE BURDEN OF WORKMEN'S COMPENSATION. IN MY FIRM LAST YEAR THOSE EXPENSES ALONE REPRESENTED THE COST OF SALARY OF ONE ADDITIONAL EMPLOYEE.

SMALL FIRMS ARE VERY CLOSE TO THE REALITY OF INCOME AND EXPENSE. WE UNDERSTAND THAT THERE CAN BE NO ADDITIONAL PAYROLL COSTS IMPOSED ON OUR BUSINESSES THAT CAN BE SUPPORTED BY CURRENT INCOME. CONSEQUENTLY, WE WILL HAVE TO RAISE THE PRICE OF OUR GOODS AND SERVICES TO THE EXTENT IT CAN BE SUPPORTED IN THE MARKETPLACE. TRADITIONALLY, SMALLER FIRMS HAVE BEEN LESS ABLE TO IMPOSE ADDITIONAL COSTS OF DOING BUSINESS ON THEIR CUSTOMERS. LARGER FIRMS HAVE A BROADER CUSTOMER BASE OVER WHICH TO ALLOCATE INCREASED EXPENSES.

WHAT IS LEFT FOR THE SMALL FIRM THEN, IS TO DETERMINE WHAT OF THIS NEW COST IT MAY ABSORB BY REDUCING EXPENDITURES. OTHER WAGES AND BENEFITS WILL HAVE TO BE REDUCED, AS THAT IS THE ONLY VARIABLE THAT EXISTS IN MOST SMALL FIRM BUDGETS.

ONE OF THE LARGER SBANE MEMBER FIRMS HAS REVIEWED THE PROPOSED LEGISLATION AND THE IMPACT OF EXPANDED COVERAGE TO EMPLOYEES WORKING 17 1/2 HOURS AND THE INCREASED EMPLOYER PORTION FROM 50% OF THE PREMIUM TO 80% OF THE PREMIUM WILL INCREASE HIS COSTS 300%. BY THE WAY, THIS EMPLOYER CHOSE TO PAY 50% OF THE PREMIUMS BECAUSE

THAT WAS THE LOCAL GOVERNMENT'S POLICY ON EMPLOYEE HEALTH CARE PREMIUMS. IS IT NOT POSSIBLE THAT MANY TOWNS AND MUNICIPALITIES WILL ALSO FACE INCREASING COSTS DUE TO THE PROVISIONS OF THIS LEGISLATION?

WITH MONTHLY HEALTH INSURANCE PREMIUMS IN OUR REGION COSTING BETWEEN $67.00 - $170.00 FOR SINGLE EMPLOYEE COVERAGE AND $202.00 - $370.00 FOR FAMILY COVERAGE, A 300% INCREASE IN EXPENSES OF THAT MAGNITUDE IS A DRAMATIC INCREASE IN THE COST OF DOING BUSINESS.

SENATOR KENNEDY, WE COMMEND YOU FOR FOCUSING THE DISCUSSION AND WE WILL WORK FOR AN EFFICIENT AND EFFECTIVE RESOLUTION, BUT THE RESOLUTION CANNOT BE A FINANCIAL BURDEN PLACED ON THE EMPLOYER ALONE.

THERE ARE NEW EFFORTS UNDERWAY ACROSS THE COUNTRY FOR PRIVATE FOUNDATIONS, THE PUBLIC SECTOR, THE HEALTH CARE PROFESSIONALS AND THE BUSINESS COMMUNITY TO WORK ON SOLVING THIS PROBLEM. SOME OF THESE PROJECTS ARE BEING PROVIDED WITH ADVANCE FUNDING BY THE ROBERT WOOD JOHNSON FOUNDATION. THE EFFECT OF THESE NEW APPROACHES CANNOT AS YET BE MEASURED BECAUSE THEY ARE IN THE VERY EARLY STAGES OF IMPLEMENTATION, BUT WE SHOULD WAIT TO BENEFIT BY THEIR EXPERIENCE. THEIR PURPOSE IS TO DEMONSTRATE NEW PUBLIC AND PRIVATE FUNDING FOR THE UNINSURED AND NEW OR IMPROVED SERVICE DELIVERY ARRANGEMENTS WHICH WOULD INCREASE ACCESS FOR THE UNINSURED. THEY APPEAR TO BE INNOVATIVE AND APPROPRIATE TO THE REGION THEY SERVICE. WHAT WE ARE ALREADY LEARNING FROM THESE PROJECTS IS THAT THIS IS A BROAD, INTRICATE AND DIFFICULT PROBLEM.

We in small business find a strict mandate to be a dangerous solution to the problem, and prefer to work toward a greater understanding of the need for coverage among small employers. Many of the newer businesses have not been provided with sufficient information on how and where to find affordable coverage.

By extending coverage in a voluntary way we would avoid a serious economic disruption in the small business sector of our economy. The economic recovery of this country in the 1980's was largely driven by the rapid expansion of the small business sector. Its ability to create jobs relieved a critical unemployment problem. We believe that Congress should display greater understanding of that marketplace and allow these companies to achieve a stronger posture without the threat of a regulated workplace. The entire world looks to the small business miracle in this Country. Having personally been a part of that miracle, I must express to you my opinion that as a nation we must preserve the opportunities that small business provides to the economically deprived, minorities and women.

While we wait for more information from the projects there is one thing that could be done immediately to expand the breadth of coverage. Congress should expand the 25% tax deduction for sole proprietors or unincorporated businesses to 100% if catastrophic coverage is included in their health insurance plans. We hope your companion legislation will move quickly and reach President Reagan for his signature and immediate implementation.

SMALL BUSINESS IS NOT REFUSING TO PROTECT THEIR WORKER'S HEALTH. WE ARE WILLING TO BE PART OF THE SOLUTION BUT CONGRESS MUST UNDERSTAND THAT TO MANDATE THIS EXPENSE IN ITS PRESENT FORM WILL PLACE THE SMALL BUSINESS SECTOR OF OUR ECONOMY IN A NON-GROWTH POSTURE. WE THINK THAT WOULD BE VERY DAMAGING TO THE ECONOMY AND TO THE NATION. IN THE SPIRIT OF FREE ENTERPRISE AND COMPETITION WE HOPE THE RESOLUTION OF HEALTH CARE COVERAGE CAN BE A COALITION OF EFFORTS AND VOLUNTARY.

Senator **Mikulski**. Mr. Swain, would you please proceed now? We know that you have a thorough analysis of the legislation from your perspective; it goes on for about 20 pages. That is going to be entered into the record in its entirety, but if you could kind of give us the highlights of your position and analysis, it would be appreciated.

Mr. **Swain**. I would be happy to summarize my testimony. Thank you very much, Senator Mikulski.

We are very pleased to be appearing here with our other colleagues, small business witnesses. We have also testified in past hearings in front of the Small Business Committee, which you also serve on. I would say that it is welcome indeed from the small business perspective that all appropriate committees of the Congress are paying as much attention to the small business aspects of this issue.

Our testimony basically makes four points. I will review those points, and then provide some brief detail.

First of all, we do not believe that the purported goals of the legislation are really going to be fulfilled by its specifies and, therefore, we think that the legislation has been a little bit overadvertised as to its impact. We think that the goals are laudable, but we need to be a little bit more specific as to the actual effect of the legislation.

Second, we believe that the impact on the small business community, particularly on volatile low-wage, volatile earning small businesses, will be quite significant.

Third, we believe that there will be an array of cost increases that are going to be very significant, and have not fully been charted out yet.

Fourth, we believe that the specific approach of the bill to attempt to limit costs by geographic pool structures is really unworkable and is more likely to increase costs.

And finally and most important, I think, as several previous witnesses have mentioned, there is an array of several alternatives available to policymakers at both the Federal and the State level, which we really feel that the Congress and State legislatures should explore before we enact this—as I think has been accurately called—very major legislation that has been proposed by Senator Kennedy and Senator Weicker.

There are two primary reasons for why the proposed legislation has been introduced: There is a concern about the number of uninsured individuals in this country and about curtailing the growth in uncompensated case health costs. Not all uninsured individuals work for business, by any means, nor do their dependents. I think that it is generally conceded that if this bill were to be enacted, and everyone that had a wage connection in effect were required to be covered by insurance, approximately 60 percent of all the uninsured people in the United States would receive coverage.

We would, however, still have a problem with uncompensated care. We would still have a problem to some degree or another with cost-shifting. And we think that although the problems of uncompensated care and cost-shifting are serious, this bill does not necessarily solve them.

Small employers are very concerned about their workers. Most small businesses do offer their workers insurance. The chart on the dais, Senator, illustrates one of the points that we make in the statement. Those small businesses who do not have insurance for their employees tend to be clustered in three industries—construction, retail industries, and service industries. Those are industries that are characterized by highly volatile numbers of workers, generally lower wages, and generally less predictable cash flows.

In fact, of all of the small businesses that do not have insurance for their workers, 40 percent of them are small retail stores with fewer than ten employees, i.e. the "mom and pop" stores that are the small business backbone of any neighborhood in any large or small town in the United States.

Now, the approach of this bill would simply set a standard, tied to the Federal Labor Standards Act. This is in effect minimum wage or tax increase if an employer fails to meet this standard, then be on her will pay a penalty based on wages.

Our point is that the people that are not meeting the standard now are people who cannot afford the standard, not employers who do not like their employees, or are selfish, or for some other reason, but they cannot afford to do it. This is demonstrated by the fact that generally the industries that have health insurance are the more prosperous industries. Simply enacting a Federal standard really does not help those businesses who are not covering their workers now and do not have the economic wherewithal to provide that coverage.

The second point is that we believe that the increased costs of this bill are far more than the direct increased costs of the insurance for the additional workers. We think that there would be another expense because indeed, the contribution standards of the bill are higher than many contribution standards currently provided by employers to employees.

A third source of increased labor costs would be the part of the bill that attempts to reduce employer cost-shifting—we think that would not just shift buts would increase costs.

Finally, the insurance representatives have discussed the geographic pool issue, and they are certainly more expert on that than we are. But I would like to point out, as several previous witnesses have, the array of alternatives available.

First and foremost, I disagree with much of what Mr. Carroll said, but I do strongly agree with him that Senator Bumpers 'proposal to increase the amount of deductibility for sole proprietorships is certainly worthy of study.

Right now, if I have a business and it is in corporate form, I can deduct my full health insurance premiums. If it is in sole proprietorship form, I cannot. There is no health policy reason or tax policy reason to retain that distinction. There may be a revenue loss, to be sure, but it is not close to the revenue cost of this bill.

Second, we believe that there are a variety of other options, including Medicaid buy-ins, transferability of some of the State programs that have been discussed by other witnesses and further efforts at cost containment that ought to be pursued by the Congress and by States before we find it absolutely necessary to take what I think is the very severe approach that this bill does.

Thank you.

Senator **MIKULSKI**. Thank you, Mr. Swain. That was an excellent summary of a rather detailed analysis that you did.

[The prepared statement of Mr. Swain follows:]

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

STATEMENT OF

HONORABLE FRANK S. SWAIN

CHIEF COUNSEL FOR ADVOCACY

U.S. SMALL BUSINESS ADMINISTRATION

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

OF THE

UNITED STATES SENATE

ON

MANDATED EMPLOYER-PAID HEALTH INSURANCE, S. 1265

JUNE 24, 1987

Mr. Chairman, and members of the Committee, I am pleased to participate in this hearing on the proposed "Minimum Health Benefits for All Workers Act of 1987," S. 1265. As the Chief Counsel for Advocacy of the U.S. Small Business Administration, I represent the views of the small business community on this issue.

My interest on the effects of this legislation is based on my extensive participation in the 1986 White House Conference on Small Business, where opposition to government mandatory benefits ranked second among all recommendations, and the Office of Advocacy's commission of a landmark study on the costs and benefits of employer-provided health care conducted by ICF Incorporated.

S. 1265 would require that employers provide health insurance coverage to all employees working more than 17.5 hours per week. Employers would pay for 80 percent of the cost of the premiums for all but the low-wage workers; for these low-wage workers they must pay for 100 percent of premium costs. Low-wage is defined as $4.19 per hour (125 percent of minimum wage) with increases based on a percentage of the consumer price index. Employers would have to provide coverage for the family of each employee, unless the employee proves that the spouse and children are covered under another plan. The bill describes the minimum standards that health benefit plans must provide, including limitations on copayments, deductibles and out-of-pocket expenses.

S. 1265 would create a system of regional insurers (in six to eight regions) to provide insurance coverage to small businesses, defined as those with fewer than 25 employees. The Secretary of Health and Human Services, through competitive bidding procedures, would select from two to five insurers in each region who must offer at least four plans to small employers. All businesses with 25 or fewer employees would be required to participate in these pools unless they have an actuarily equivalent plan in effect the day before the effective date of this legislation.

THE UNINSURED AND UNCOMPENSATED CARE

There appear to be two primary reasons for the introduction of S. 1265: (1) to reduce the number of uninsured individuals, currently estimated to be between 32-37 million persons; and (2) to curtail the growth in health care costs, notably the costs of uncompensated care, which in 1985 totaled approximately $7.4 billion, or 5.7 percent of $163 billion in hospital charges.[1] Unfortunately, the bill falls far short of its intended goals and its costs would be exorbitant for all employers and employees, especially those in small businesses. S. 1265 could increase costs to employers and workers by as much as $100 billion, increase unemployment, especially among low-wage workers, and is contrary to current competitiveness policies.

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[1] American Hospital Association, Chicago, IL, 1987.

Let me emphasize at the outset that small employers are very concerned about the problems of uninsured workers and the high costs of health care. Health benefits are among the most common fringe benefits offered by large and small employers. In order to attract and retain employees, employers strive to establish health care plans. But it is not surprising that most uninsured workers are found in small businesses where employment and profits are volatile and the costs of health insurance are higher relative to larger firms.[2]

As is true for all fringe benefits, the prevalence of health care benefits increases with firm size (Chart 1). The largest drop off in coverage occurs in firms with fewer than 25 workers. Of the working uninsured, 6 million wage-and-salary

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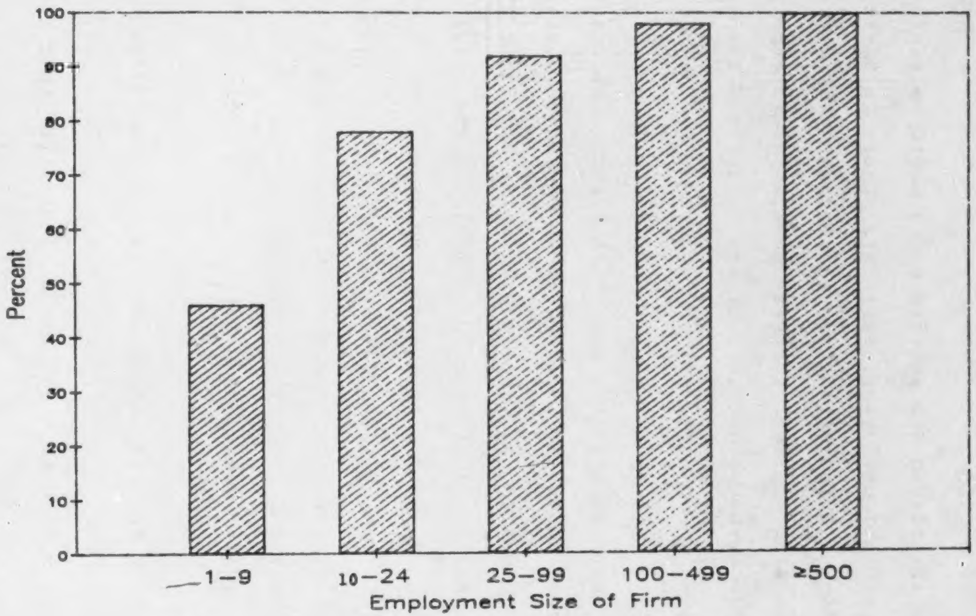
[2] For further comment on why small business health costs are higher see Testimony of Frank S. Swain, Chief Counsel for Advocacy, Small Business Administration before the Committee on Small Business of the U.S. House of Representative on "New Directions for Small Business and Health Care," May 6, 1987.

CHART 1

Percentage of Firms that Offer Health Benefits



Source: U.S. SBA, Office of Advocacy, ICF Report, 1986 workers are in firms with under 500 workers, with the majority employed in the smallest companies of fewer than 25 employees. In addition, another 1.6 million of the uninsured are business owners, primarily sole proprietors (Chart 2).

It is important to observe that even without considering the costly and disruptive effects S. 1265 would have on business, the bill would never cover all of the uninsured. According to the Employee Benefit Research Institute, if all employees and dependents working 18 or more hours per week were covered through employer-sponsored health plans, 34.1 percent of the uninsured population, or 11.9 million people would remain uninsured.[3] This estimate is low, however, for it does not include the increase in the unemployed uninsured population which would likely result from S. 1265.

Similarly, employer-mandated coverage is not a cost-effective way to alleviate hospital uncompensated care bills. By the sponsors' estimate, it is a $25 billion solution to what is at most an $8 billion uncompensated care problem. Much of the $8

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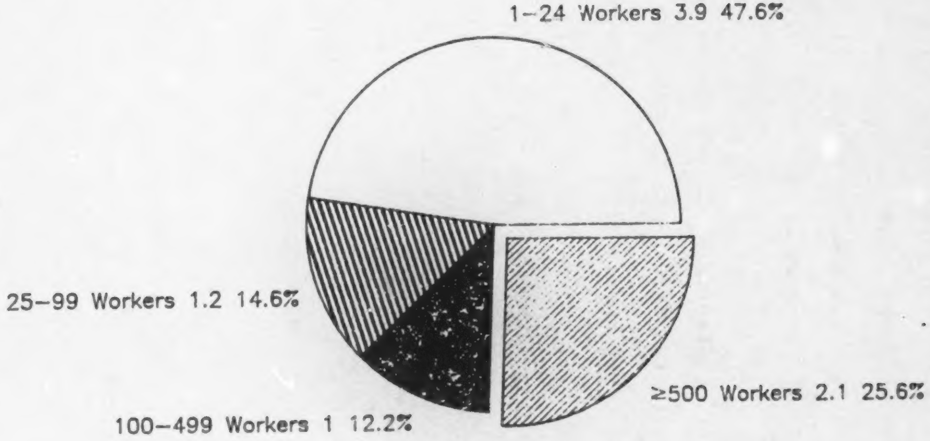
[3] "The Erosion of Health Insurance Coverage Among the Nonelderly Population: Public Policy Issues and Options," Deborah J. Chollet, Ph.D., Hearing before the United States House of Representatives, Committee on Small Business, May 6, 1987, Table 14.

CHART 2

Workers Not Covered by Any Health Insurance by Firm Size, 1984
(Millions)



Employment Size of Firm

Source: U.S. SBA, Office of Advocacy, Census SIPP Data, 1984 billion uncompensated care tab is from mental health and complicated pregnancy care, which are benefits not covered under the proposed minimum plan. Another large portion of uncompensated care is attributable to bad debt, i.e., insured individuals who do not pay deductibles or copayments. S. 1265 would not eliminate these costs.

A TAX ON EMPLOYERS AND EMPLOYEES

But perhaps the greatest concern of the small business community is the staggering cost of this proposed legislation, the cost not only in dollars to small businesses, but in diminished hiring and employment. In other words, the cost of guaranteeing every worker employer-paid health insurance is fewer jobs.

A recent analysis conducted by the Institute for Research on the Economics of Taxation (IRET) and Fiscal Associates, Inc.[4] estimates that S. 1265 would increase 1988 labor costs by over $100 billion. The study focuses on four sources of increased costs.

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[4] Institute for Research on the Economics of Taxation and Fiscal Associates, Inc. forthcoming July report on the "Costs of Kennedy Mandated Health Care", 1987.

First, the mandated minimum benefit package would cost more than the average package for existing plans since in a significant number of cases the employer contribution for existing family plans would increase to meet the standards of S. 1265. Second, would be the direct expense of the approximately 17 million uninsured workers and their families who would receive employer-sponsored health insurance.[5]

A third source of increased labor costs comes from mandatory duplicate coverage. Under the proposed legislation, all workers would be insured by their own employer, even if they could be covered under another employer's plan. For example, in a family consisting of two income-earning spouses and an 18-year old worker, each family member would pay separate premium contribution, deductible, and copayment expenses. A family with two income-earners and children would have one family plan and one individual plan. This is not only more costly, it is more constraining in terms of the family's choice in selecting benefits. Perhaps one parent has the option of a cafeteria plan and could take advantage of pension or child care benefits, while remaining on a spouse's health plan. If forced to accept separate employer-sponsored health benefits, however, the family's total nonwage compensation is lowered.

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[5] The estimate of 17 million additional workers, which is also used by the Congressional Budget Office, is from Current Population Survey data and slightly higher than estimates from the Survey of Income Program and Participation (SIPP) data.

Finally, S. 1265 incorrectly assumes savings for small employers through regional pooling arrangements. Despite the bill's presumption, administrative costs would not be significantly reduced and would add to the total cost of the program. Other administrative costs imposed by the bill include the cost of calculations for employers with plans to assure that their plans are the actuarial equivalent of the minimum benefit plan standard. Employers are already subject to the administrative requirements of COBRA's continuation coverage and the nondiscrimination rules under the Tax Reform Act of 1986. Second, payroll deductions will vary depending upon whether a worker is full-time, part-time, or has worked at least one month. (The current average waiting period for all employers is 3 months).[6] These computations for enrollment and contributions are onerous administrative burdens on employers.

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[6] "Health Care Coverage and Costs in Small and Large Businesses", ICF Incorporated, April 15, 1987, Table III-12.

S. 1265 would create increased demand and utilization of health services, thereby, raising, not reducing, overall health costs. The bill's prohibition of exclusion of pre-existing health conditions from plans would also likely increase overall health costs.

GEOGRAPHIC REGIONAL POOLS FOR SMALL BUSINESS

Apparently the proponents of the legislation realize that small firms have legitimate economic difficulties purchasing health insurance. But rather than looking to incentives to purchase or insurance deregulation to stimulate new products, the bill proposes an expensive and impractical scheme of federally regulated insurance pools.

S. 1265 attempts to address the problems of small business health plans by pooling together within a defined region firms that employ in an average year 25 or fewer employees. Upon joining a pool, a firm is prohibited from purchasing insurance elsewhere. According to proponents of this scheme, administrative costs would be lowered approximately 17 percent.

This scheme cannot conceptually or actually result in cost savings. The result would almost certainly lead to cost increases. For instance, S. 1265 assumes incorrectly that a large pool of employers and employees will greatly reduce administrative burdens because of decreased costs in marketing and overall economies of scale. In reality, however, many of the factors that make small business insurance costs high remain. The volatility of small firms moving in and out of business and the rapid turnover among small firm workers, which is especially high in firms currently lacking health insurance, would keep administrative costs high.

Savings are also wrongly anticipated to result from an assumed rush by small businesses to join together in trade associations and business groups to purchase insurance from the regional insurers. These groups, such as local chambers of commerce, would perform some of the administrative functions of the insurance companies and, therefore, the insurance companies would reduce premiums for small business purchasers. I believe this conclusion is naive in two respects.

First, this line of thinking assumes that a local chamber of commerce would be able to handle the administrative aspects of insurance more cheaply than an insurance company. I suspect not. It ignores the cost to the small business of joining the trade association and paying for the association to develop an insurance program. Trade associations would have to market their services and develop expertise to handle insurance matters. Administrative service costs would merely be passed on to small business members from the trade association rather than the health insurance carrier.

Second, the division of the market scheme ignores the realities of underwriting. S. 1265 intends to lower pooling costs by requiring insurers to bid in a geographic market on a competitive basis. Competitive bidding per se would not result in reasonable prices in what are totally untested, unpredictable markets. The likelihood that insurance companies would submit high bids has been overlooked. Insurance companies have no past record on which to rely when setting rates and would conservatively calculate premiums. These new groups would be larger, include workers who have never had coverage before, as well as workers and dependents with preexisting conditions, and be comprised of widely disparate businesses.

Elimination of medical underwriting, shortened waiting periods, and increased demand would also lead to higher premiums for all employers, small and large alike. For firms which cannot afford insurance currently, the geographic pool approach would not lower coverage costs, but raise them.

MANDATES INHIBIT FLEXIBILITY, JOB CREATION, AND COMPETITION

Although it is traditional that workers obtain health coverage through their employer, it is also traditional that employers maintain a voluntary flexible benefits system. This flexibility, or lack thereof, may determine (a) whether an employer goes into business, (b) the number of workers that can be hired, and (c) the kinds of benefits an employer may offer and the degree to which they can be tailored to meet the needs of a work force.

Small businesses, with a well documented record as job creators, have been successful in large part because of their ability to readily adapt to the needs of the economy and the work force. Small employers are able to tap the labor pool and accommodate part-time workers and employees desiring flexible hours and benefits (e.g., offer higher wages in place of other benefits). Mandated benefits of any kind severely restrict that flexibility-both in terms of who small employers can and will hire and what benefits can be offered.

Many government policies are promoted because they will increase the job generation contribution of small firms. Mandated health care coverage is a policy that does the opposite--it makes it more expensive to hire employees. I think we need to be upfront about the consequences of a mandate and label it as Princeton University's Uwe E. Reinhardt does: a tax on employment and entrepreneurship.[7] The impact of a mandate not only affects hiring patterns of existing companies, but would discourage new entrepreneurs by drastically increasing start-up costs.

In the introduction of S. 1265, this legislation was likened to increasing the minimum wage. In that respect we agree with the proponents' labeling. And I believe that with increased labor costs unemployment would increase if this bill were to become law. The proponents' estimate that this bill would add 40 cents per employee per hour, would be equivalent to a 12 percent increase in the minimum wage.

Adding the proponents' annual composite premium estimates of $1,186 to an annual minimum wage salary would increase compensation from $6,968 to $8,154, a 17 percent increase. Employers must pay the full premium for low-wage workers. Where is the increased labor cost to come from? Lower and minimum wage employees' compensation cannot be reduced to absorb the added benefit costs, with the result being increased layoffs or reduced hiring. Because wage and health costs vary by region, the expected costs would be even greater in certain parts of the country.

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[7] "Should All Employers Be Required by Law to Provide Basic Health Insurance Coverage for their Employees and Dependents?" Uwe E. Reinhardt, Ph.D., paper for the Employee Benefit Research Institute policy forum on "Government Mandating of Health Pension, and Other Employee Benefits," April 27, 1987.

It is likely that in order to avoid mandated health costs employers would hire more employees who work fewer than 17.5 hours a week. Moreover, because we know that an increase in the minimum wage led to a reduction in the number of hours worked among employed workers,[8] employers would likely reduce hours worked by employees. Alternative employment arrangements, such as independent contractors, would also become more prevalent in order to avoid employer mandated health costs. Employer mandated health insurance is only likely to increase the pool of unemployed uninsured.

Employer-mandated health insurance would most affect three industries that currently experience low rates of coverage: retail trade, certain services, and construction.[9] These industries are characterized by low and variable profits and high worker turnover. One estimate shows that if S. 1265 were enacted there would be one million fewer jobs than would otherwise would be generated between 1988 and 1991.[10]

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[8] "The Erosion of Health Insurance Coverage Among the Nonelderly Population," p. 29.

[9] Data on prevalence of coverage in retail trade, services, and construction relative to other industries may be found in "Health Coverage and Costs," Table III-6.

In 1961 minimum wage increases significantly curtailed employment in the retail trade sector. For each five percent increase in average hourly labor costs during the 1960s retail trade employment was reduced by 5 percent. In the service industries, another industry where many firms experience relatively low coverage, a ten percent increase in minimum wage results in a one percent reduction in employment.[11]

The third industry which presently has low health coverage is construction which employs many seasonal workers. The administrative costs of doing business for employers in this industry are considerably higher because of the higher worker turnover. S. 1265's requirement to provide health coverage to workers after 30 days of employment would exacerbate such costs.

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[10] Institute for Research on the Economics of Taxation and Fiscal Associates, Inc., forthcoming July report on the "Costs of Kennedy Mandated Health Care," 1987.

[11] Industry unemployment data due to minimum wage increases are from "The Erosion of Health Insurance Coverage Among the Nonelderly Population," p. 29.

Current public policies seek to encourage American competitiveness abroad. Individuals favoring a mandate often assert that businesses most affected by this legislation do not play a large role in the international economy. Although it may be true that the majority of these businesses are not directly involved in exporting goods or services, many are suppliers to companies that do compete internationally. Higher costs for a supplier surely affects costs for the purchasing firms. More important is the ripple effect felt on the economy from mandated employer health insurance. Injecting huge costs, whether $25 or $125 billion, into the economy and increased unemployment would weaken, not strengthen our ability to compete.

VOLUNTARY POLICY OPTIONS

The increased knowledge of health care and its importance to small employers is exemplified by the ranking of this subject as second among all recommendations voted upon by small business delegates to the 1986 White House Conference on Small Business. Small employers are not just saying "no", but have suggested sound voluntary incentives to expand coverage in small firms and among low-income workers. These alternatives address the reasons why small firms currently lack coverage and help to ameliorate those problems.

For example, data show that unincorporated business owners are significantly less likely to offer health insurance. A full extension of the tax deduction for health premiums for these business owners would expand coverage to them and their workers. To be fair to the self-employed, there should be no conditions on the tax deduction extension as there are none presently on corporations.

Other voluntary options include: a limited preemption of state mandated benefits for privately offered low-cost catastrophic plans; an examination of the success/transferability of more than 15 state pilot programs which target uninsured small business workers and low-income persons; and a focus on private sector and government education and cost containment programs.

These solutions are not necessarily simple and in some way involve some foregone revenues. However, they are considerably less costly and onerous than the S. 1265. I would be happy to expand on these ideas and provide additional data on the costs and benefits of health care by size of firm. Policy efforts to minimize the number of medically uninsured and costs of health care and uncompensated care must more effectively take into consideration the nature of the unavoidable problems encountered by small firms. S. 1265 imposes new burdens on all businesses, those with and those without health insurance benefits. The cost of this proposal accumulates into a $100 billion sledge hammer. Small businesses will play a key role in reducing the number of uninsured individuals, but they will do this more effectively and without harm to the economy under a voluntary, flexible approach.

Mr. Chairman, thank you for the opportunity to appear here today. I would be happy to answer any questions.

Senator **Mikulski**. Mr. Carroll, I just want to underline one of the points you made in your testimony. And I say this because one of the things that I share in common with Mario Cuomo and Margaret Thatcher is that I am the daughter of a grocer. My mother and father run a small neighborhood store in an ethnic neighborhood in Baltimore. And from my observation, all of their life and now, even in retirement, they get nailed by insurance.

Dad paid an enormous premium for insurance for himself and mother, and some of the people working for him; and then in retirement, because he was small business, some of the things you brought up, Ms. Griffin, he had to get insurance as if he were an individual rather than belonging to a group of grocers.

Therefore, my question to you is, without a mandatory program so that everyone participates, wouldn't that ensure a requirement for community ratings to get rid of discriminatory medical underwriting and opportunities to participate in managed care systems, and perhaps a better deal in the rates?

Mr. **Carroll**. Well, if I understand you correctly, Senator, what I said was this, that what I like about the pool and the regionalization, by spreading the risk out and eliminating health statements, people like your father would have had an opportunity to participate in the pool, and he would be covered. Whereas, if he tried to get insurance now, chances are he would be denied because of his age.

That availability is not there presently. If the small businessperson is over 50 years old, is 60 years old, and he wants group health coverage, he cannot obtain it if he cannot pass a health statement.

Not all HMOs have guaranteed issue. A lot of HMOs require health statements. Many HMOs will allow sole proprietors in, individuals into their HMO when they have open enrollment, so that he would be covered.

The regional pool will spread the risk. And this is probably one of the few times that Frank Swain and I have been on opposite sides, but I think that the Kennedy bill, with improvements, if we all work together as has been suggested here, particularly the small business community—the Senator does not want to hurt small businesspeople—I think the pool concept would reduce the premium. I think that by eliminating health insurance you would reduce that uninsured population significantly within the small business community because, as sure as I sit here, many small business people, regardless of cost, cannot get health insurance, and they deserve it.

Senator **Mikulski**. Well, what I found so interesting about your testimony was that you talked about the people who do not have insurance are very often the proprietors themselves; it is not only the employer-employee relationship. And I think this is one of the issues we are trying to grapple with.

One of the great things about small business is, first you provide a job for yourself, and then usually for a few others. And that has been the genius of small business, as Ms. Griffin outlined.

And I think the fact that Ms. Griffin has a business whose purpose is to advise business on how to comply with government regulations to pension programs shows that sometimes we can make things enormously complicated. I am glad you are earning a living off what we have done, Ms. Griffin.

Ms. **Griffin**. Well, I did not say that.

Senator **Mikulski**. But I think what we are also concerned about is not only the obvious consequences of the legislation, but the unintended consequences.

However, saying that, do you feel that you could make some recommendations that would make this legislation acceptable to some of its critics in the small business community?

We know that they are concerned that this is going to add to the cost of doing business. We have had a rather detailed analysis of the fears. I think you have given us a factual analysis, Mr. Swain.

Ms. **Griffin**. Well, I have a few things I would like to say in response to that.

First of all, we are in a very changing economy here in the 1980's. There is still a lot of information that we have yet to accumulate and understand about what is happening in the small business sector of the economy. I understand the legislation is going to have added to it a provision to protect those companies in their early start-up years.

But there is a myth that the first 2 years are the hardest—that is a myth in small business. It is never easy.

I think we have a large population of small employers today who have been released from the larger jobs, the larger companies—we have many people from the auto industry, and I have enjoyed reading about their great energy and their courage to go out and establish their own firms and so on. They are in their very early years. They need a great deal of education, they need a great deal of support. They want this kind of coverage. They want to provide it for their employees and for their own families and dependents. I think we have to be very, very sensitive to those people.

We have heard a lot about cost-shifting today from big business, and the shifting of the burden of the responsibility for insurance. I think for the small business community, I would like to say that there has been a shifting of jobs in this decade; there has been a shifting of millions, maybe 10 million jobs, from the large employers who customarily provided these benefits, to the smaller employers who are just learning and are just getting underway, but they are very serious, and they are very sincere, and they will provide these benefits if they are available and accessible, and they would like to do it on a voluntary basis.

Senator Mikulski, I made myself a promise that I was able to establish my business in an environment that was very, very open to my creativity and my energy and my willingness to assume risk. And I want to make certain that that same environment is still there for future generations. I do not want people in this country to come up into a regulated work force where they do not dare try, because I do believe that for myself and for many, many people, it has been an opportunity to professionally advance, economically improve myself, and to make great contributions as many of my peers have done.

Another problem that I think we have is that we have such an underground labor market here. I think many, many of our uninsured are in this underground labor force. As an employer, I would not consider having anyone in my employ who was not a reported income earner.

Senator **Mikulski**. Ms. Griffin, are you talking about the illegal aliens, or are you talking about the cash-only barter?

Ms. **Griffin**. I am talking about the cash-only, and the people who will not come—we have just recently read about the innkeepers and the restaurateurs on Cape Cod who cannot find people to fill their jobs this summer, because people will not take a job where their income is going to be reported. I wonder how much of that we have across this Nation. We have many, many employers who would be willing to provide insurance and other benefits to their employees, but you cannot provide it if the employee will not be part of your payroll.

Those are just some of my other concerns.

Senator **Mikulski**. That was a very interesting insight.

Mr. Swain, Senator Kennedy had some questions, and we are going to turn those over to you for response.

Mr. **Swain**. Fine.

Senator **Mikulski**. And I will not take your testimony as endorsing hospital cost containment legislation for the Reagan administration.

Mr. **Swain**. Thank you. That would be an overly broad reading of my statement, I think.

Senator **Mikulski**. Your job is to be an advocate for small business, and we thank you for your very thorough analysis, which I intend to read in more detail. And we thank the panel for testifying.

[Additional material supplied for the record follows:]

The Hartford Courant
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NEWSPAPER IN AMERICA

5/22/87
page 14

EDITORIALS

Health insurance for all workers

Most employed Americans take health insurance for granted, and understandably so. Its importance has made it the primary job benefit, one whose existence usually goes without saying. But some employers still don't provide it, leaving their workers to fend for themselves. In this era of expensive health care, that's ample reason for Congress to step in.

A bill drafted by Sen. Edward M. Kennedy, a Massachusetts Democrat, would require all employers to offer basic health insurance benefits to full-time employees (defined as those who work at least 17½ hours a week) and their dependents. A dedicated co-sponsor is Connecticut Republican Lowell P. Weicker.

About 37 million Americans don't have health insurance, according to Mr. Kennedy. That exposes them and their families to financial ruin, and forces the government to shoulder the burden of paying for their medical care when their personal resources are exhausted. The health consequences can't be ignored, either: A person without insurance may postpone or forgo needed care for himself or a child, possibly making a dangerous condition worse or spreading disease.

This legislation wouldn't give all 37 million people insurance protection, but it would eventually make sure that there was at least basic coverage for the approximately two-thirds of them who are either employees or dependents of employees. And that would be a considerable accomplishment.

The insurance required by the bill would cost employers and workers about $25 billion a year, Mr. Kennedy says. Employees making less than $4.19 an hour wouldn't be charged for the coverage; other workers would pay 20 percent of the premiums, and employers 80 percent. All of the insurance would be privately obtained.

The impact on moderate to large corporations would be minor because so many of them already offer employee health insurance to full-time workers. Small employers who don't provide health coverage might swallow hard, but the bill's backers have made allowances for them.

For the first two years, businesses with 10 or fewer employees only would have to provide insurance for catastrophic illnesses. A companion bill would give small businesses the same insurance tax breaks that big ones have. And small employers could buy insurance through pools to reduce their premiums.

Group health insurance is a necessity for almost all Americans. Practically no one can pay for medical expenses without help. Individual health policies are far more expensive than group coverage. Some people belong to private organizations through which group insurance can be bought, but no one should have to join an organization to obtain affordable insurance.

Mr. Kennedy's bill is thus appealing in several ways. It can better protect the nation's health, promote economic justice and, not least, bring peace of mind to many of the Americans who, perhaps all of their lives, have been afraid to go to the doctor.

STATEMENT

of the

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to the

Committee on Labor and Human Resources

United States Senate

on

Access to Health Care

June 24, 1987

This document was developed by the American College of Emergency Physicians' Government Affairs Committee (Stephen Dresnick, MD, FACEP, author), and was approved by the Board of Directors on March 7, 1987.

"ACCESS TO EMERGENCY MEDICAL CARE: EMERGENCY PHYSICIANS AND UNCOMPENSATED CARE"

The Problem

The problem of access to care by indigent patients has existed as long as there have been physicians. In the past, patients who were unable to pay for medical services often bartered for care with food or livestock. Although the enactment of Medicare and Medicaid in the mid-1960s was expected to increase access to care for the needy, the problem remains.

The current crisis in indigent care has been brought about by several factors. Hospitals are reviewing the amount of charity care they provide because although committed to providing high-quality medical care, they are keeping an eye on the bottom line. Hospitals are cutting back services because of increased indigent loads and an inability to remain fiscally sound on the basis of patient revenues. This has occurred in part because of the increase in the uncompensated care problem. The amount of uncompensated care provided by hospitals increased by more than 50 percent in a two-year period — from $6.2 billion in 1982 to $9.5 billion in 1984. In addition, people who previously donated to not-for-profit institutions no longer do so, perhaps because the hospital is no longer viewed as a center of community activity.

Other changes in the health care environment also threaten the access of indigent patients to medical care. Physicians in private practice are increasingly reluctant to care for indigent patients, as evidenced by the fact that most indigent care is provided by public institutions, which constitute only 21.6 percent of the nation's hospital beds. Many physicians send patients to publicly owned or supported institutions because of their affiliation with teaching programs. The indigent have been a major source of patients for many residency programs. Indigent patients often are the sickest patients because they frequently postpone medical attention. Physicians also cite malpractice concerns and poor compliance with treatment plans as reasons for not taking on a large share of uncompensated care.

Federal health programs intitially designed to meet the health care needs of the elderly and the poor have experienced expenses far in excess of early projections. The government has had to examine costs closely and tighten enrollment criteria, as well as seek other ways to limit expenses. In the past, hospitals and other providers had been able to shift costs to other third-party payors. This is no longer possible, as large businesses examine their health care expenditures and attempt not only to limit their cost increases but also to actively negotiate reduced rates with hospitals and physicians. In addition, more patients are enrolled in health maintenance organizations, which rely on discounted hospital and physician rates. In this environment, there is no economic reservoir to which the costs of providing indigent care can be shifted.

One difficulty in dealing with the problem of indigent care is defining the medically indigent. A more precise definition of the terms used is necessary before policy and strategies are developed. Although many descriptive terms have been used, most public policymakers are familiar with the term "uncompensated care." This is usually defined as care provided by a hospital or physician to patients who are unable to pay, as well as bad debts arising from patients who presumably can pay, but choose not to do so. The latter group also has been termed "medically indigent," even though they do not fall within federal or state poverty level guidelines. Their income is more than that needed to qualify for Medicaid, yet they have little money to pay for health care.

Approximately 10 to 15 percent of the population is "medically indigent," which translates into roughly 35 million people. Nearly 70 percent of uncompensated care goes to uninsured people. A large percentage are employed or dependents of employed. Approximatley 90 percent of the employed and uninsured have no company insurance coverage, make between $8,000 and $22,000 per year, and work for companies employing between five and 50 people. Almost 60 percent of the unemployed/uninsured are unemployed for less than four months. Most lose their health care benefits when they lose their jobs, but do not qualify for assistance programs. In the past, many of the uninsured qualified for Medicaid.

However, the Medicaid "safety net" for the poor has frayed since the mid-1970s. During 1975, 63 percent of the population at or near the poverty level were Medicaid recipients. This number has declined steadily and was less than 50 percent in 1985.

The Emergency Physician and Indigent Care

Emergency physicians have a unique perspective on indigent care and are perhaps affected more than any other medical specialists. Surveys by the American College of Emergency Physicians report that an average of 31 percent of emergency physicians' charges are uncollected. Many reported uncompensated care levels as high as 50 or 60 percent of gross patient charges.

One reason that emergency physicians provide so much uncompensated care is that many other physicians provide less. In Orlando, Florida, for example, a recent survey revealed that less than ten percent of physicians in the county accepted Medicaid patients. Many reported that they would not see patients in their offices unless they demonstrated an ability to pay. The inability of the indigent to access outpatient primary care has resulted in their seeking primary care in emergency departments. In the past, this activity was not disuaded for several reasons. First, emergency physicians have taken the position that the patient determines whether an emergency exists. In addition, the majority of states, as well as the federal government, have passed legislation mandating that patients presenting to emergency departments be seen and evaluated regardless of their ability to pay. As more indigents with nonurgent problems enter the health care system through the emergency department, fewer resources are available to others in need of emergency care.

As emergency physicians have experienced an increase in uncompensated care, reimbursement from other sources has declined. The Tax Equity and Fiscal Responsibility Act of 1982 mandated a 40 percent decrease in payments for emergency visits for Medicare patients who were determined not to have a "true" emergency. At times, this determination has been made somewhat arbitrarily by Medicare carriers. In addition, emergency department contracts may require emergency physicians to be "participating physicians" in the Medicare program, which, in general, leads to lower reimbursement. As more patients enroll in HMOs and preferred provider organizations, contracts with hospitals mandate discounts for emergency visits. In addition, many payors have begun to "collapse" CPT-4 procedure codes and recognize only one level of emergency services (usually the lowest) for reimbursement purposes.

The issue of adequately compensating primary care physicians for providing needed medical care is often overlooked. Most proposed solutions focus on paying for hospital services provided to indigent patients. The American College of Emergency Physicians strongly supports the concept that adequate funding must be available to ensure that quality primary and preventive care is available to all. In addition, the College supports the premise that emergency physicians should receive adequate compensation for the services they provide to indigent patients.

Solutions to the indigent care problem must include those elements that ensure that physicians and other health care providers remain accessible to these patients. It is not reasonable to proffer a system that does not adequately fund primary and preventive care. Such a system would result in patients receiving their first contact care during an emergency, one that might have been prevented by early intervention. Solutions to the uncompensated care problem must provide for accessible, economical primary care -- care that may prevent costly hospitalization.

The Solutions

Although access to care and uncompensated care is a national problem, it is unlikely that the federal government will find the ultimate solution. Because of staggering budget deficits, Congress may be reluctant to expand currently existing federal programs. Certainly, there is little prospect of the federal government covering the large group of uninsured who are employed or their dependents. Medicare, which assures payment for medical services to the elderly, does not recognize or contribute to the cost of charity care or bad debt. Although Medicaid is federally funded, it is administered largely by the states.

Assuring access to health care for the indigent has become one of the most pressing issues for state governments in the 1980s. Since 1984, twenty states have established commissions to study the financing of health care for the indigent. The proposed involvement of states in the provision of medical care to the indigent varies widely in design and implementation, and includes state-mandated and state-funded programs, as well as joint state/local programs.

The Medicaid program, which covers more than 20 million patients, seems the obvious source of increased funding for care of the indigent. In fact, since 1985 twenty-eight states have expanded their Medicaid programs to provide some care to the indigent by modifying eligibility requirements. However, in addition to federal government restrictions on such expansion, there is inadequate funding for sufficient expansion of Medicaid programs to cover all patients in need.

States have had to look at new and innovative ways of expanding coverage to increase access to care. Some have proposed legislation mandating continuation of health insurance for a designated period after employment has terminated, as well as legislation allowing conversion of group insurance policies to individual policies at group rates. Three states have developed catastrophic health insurance programs.

Several states have chosen to address the issue by establishing minimum uncompensated care requirements. Under a variety of schemes, hospitals would be required to provide a designated amount of uncompensated care or to provide funds to help pay for uncompensated care at other institutions. Other states have tied minimum uncompensated care requirements to certificate of need approval. With the attention being given to prepaid health plans, several states have instituted similar plans for their indigent populations in an attempt to deliver more cost-effective care.

Conclusion

The problem of indigent care is complex, and the proposed solutions vary. No single method has been shown to be the best. Many proposals have only recently been instituted, and it may take several years to determine their value.

Unless emergency physicians become involved little will be done to address their concerns. Some policymakers believe that there is no problem with access to emergency care. Continuing budget deficits, the resulting reluctance to spend new federal dollars, and strong opposition on the part of employers to take on additional burdens make action in the short term unlikely unless extreme political pressure is applied. Even then, there is unlikely to be sympathy for increasing physician payments when many already view physicians' incomes as more than adequate.

Emergency physicians are not alone in dealing with uncompensated care. To solve this problem, they cannot and must not work alone. All sectors of our society must work together to find the best solution for access to care for the medically indigent. Emergency physicians should join in the development of coalitions with other interested groups in pressing for legislative reforms. Emergency physicians also can educate the public, as well as those involved in trying to find solutions, about the role emergency physicians play in providing uncompensated care. Emergency physicians must alert the public to the threat that the current crisis has on their ability to provide quality emergency medical care.

While it would be premature for emergency physicians to endorse a single proposal, it is necessary to adopt the following principles, on which any solution must be based:

1. There must be adequate access to primary and continuing care.
2. Emergency medical care should be available to every patient in need.
3. There must be adequate payment to emergency physicians for services provided to indigent patients to ensure the continued availability of high-quality emergency medical care.

Emergency physicians, because of their commitment to quality emergency medical care, will continue to provide care to all patients in need, regardless of ability to pay. Emergency physicians must become involved in the discussions concerning uncompensated care and work with other interested groups to seek satisfactory solutions to this complex problem.

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American Farm Bureau Federation

WASHINGTON OFFICE
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July 2, 1987

The Honorable Edward M. Kennedy, Chairman
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Re: S. 1265 Mandated Health Insurance

Dear Senator Kennedy:

The American Farm Bureau Federation is the nation's largest general farm organization, with a current membership of 3.5 million member families in 49 states and Puerto Rico, who have voluntarily joined and paid dues in some 2,800 County Farm Bureaus. We estimate that the membership includes some 85 percent of the 750,000 agricultural employers who would be directly affected by S. 1265.

We oppose compulsory national health insurance in any form. The bulk of agricultural employers employ fewer than 10 people on a year-round basis, but a great many of them have relatively short periods of peak employment that require seasonal employment. Some four-fifths of all hired farmworkers are temporary or seasonal.

Although this bill attempts to soften the blow to small employers by exempting those who have been in business for less than two years and who employ less than 10 people, this would not take care of the seasonal problem. It is simply not feasible for agricultural employers to provide health insurance to workers who are employed by them for short periods of time--usually four months or less. The bill provides for a maximum of 30 days' waiting time before coverage must be provided to an employee. Many of these seasonal workers are students from middle class families who are covered by a family health insurance policy.

Most of the State Farm Bureaus have been offering health insurance coverage to Farm Bureau members and their families and to their employees and families through Blue Cross/Blue Shield group plans, or through other plans, some of which are provided by Farm Bureau-affiliated insurance companies.

We are opposed to the provision in the bill that requires small business and businesses not now offering coverage to purchase the mandated coverage from an insurance carrier selling policies in a multistate region. We realize the purpose is to keep the cost of the coverage at a minimum, but employers should be free to shop for coverage without this undue federal intrusion. We know of instances like Garden State Hospitalization Plan in New Jersey, a nonprofit plan operating only in that state, that has provided economical and dependable service for many years. They would likely be forced out of business by this provision in the bill.

Farm Bureau has taken the lead in sponsoring legislation to amend the tax laws so as to provide a deduction for health insurance costs incurred by farmers and other self-employed persons. That goal was only partially achieved in the recent tax reform legislation, and we note with considerable interest your stated intention to introduce companion legislation to liberalize such a tax deduction.

We recognize that a lot of consideration has gone into the drafting of this legislation and that it mandates what most would consider to be only basic protection, but it is the compulsory nature of this legislation that necessitates our opposition.

As has been pointed out, there is no free lunch in providing for and paying for health insurance or any other social benefit. All such costs are inevitably passed along to consumers or taxpayers. It is true that the cost of indigent health care is already being provided by the taxpayers through Medicaid, VA hospitals and other programs, or by higher hospital and physician fees. However, we do not agree that the way to solve that problem is to compel employers to provide health insurance as an employee benefit, with a maximum of 20 percent of the cost to be borne by employees. We concede that this proposal is more acceptable than earlier proposals that amounted to socialized medicine, but we prefer an incentive approach rather than a mandatory approach to alleviating the problem.

We feel this Congress is moving too rapidly and too far in the area of mandated employee benefits, as if that approach is a cure-all for social problems. We certainly do not agree that mandated health insurance should be viewed as the next logical step after the minimum wage. We think the federal minimum wage is an anachronism and should be replaced with a better approach to alleviating poverty.

This legislation represents a serious threat to the future viability of many family farms that are having a difficult time holding onto their farms and working themselves out of debt. The last thing they need right now is an additional cost mandated by the federal government.

We ask that this letter be made a part of the hearing record on this legislation.

Sincerely,

John C. Datt
Executive Director
Washington Office

cc: Democratic Members of the Committee

87-30

SUBMITTED STATEMENT OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS TO THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE ON ACCESS TO HEALTH CARE SERVICES

June 24, 1987

The AFL-CIO is pleased to have this opportunity to comment on S. 1265, the Minimum Essential Health Care bill, requiring employers to offer workers a minimum health benefit plan as a condition of doing business. In the United States, 16 percent of our population, or 37 million people, are uninsured -- a situation which independent and respected authorities, such as the Robert Wood Johnson Foundation, have recently termed "a crisis". We commend you, Mr. Chairman, and your colleagues for taking the initiative to assure that workers and their families who constitute 75 percent of the 37 million without coverage, will receive health care protection.

Every other industrialized country except South Africa has a national health care policy guaranteeing all citizens access to health care services through an organized system of public and private health care coverage. Your legislation acknowledges that government alone cannot solve this problem. Rather, it requires a partnership between the public and private sectors. That is not to say that government is presently doing enough, but it is time for Congress to specify some basic requirements with respect to health care that employers wishing to do business in this country must meet.

There are those that state categorically that government should not determine which employee benefits should be provided to workers and that the free market should be allowed to work. We say that government cannot afford to sit on the sidelines, given the severe economic and health care consequences associated with the present policy of non-intervention.

The proportion of Americans who had not visited a doctor's office in the preceding 12 months nearly doubled, from 19 percent in 1982 to 33 percent in 1986. About one million Americans were turned away from doctors' offices or hospitals because they could not pay. Children, pregnant women, and the seriously ill could not afford or obtain much of the care they needed. A disturbing 15 percent of pregnant women received no health care during their first trimester, with rates double that for low-income women. Approximately, 20 percent of those with hypertension had not had their blood pressure checked within the year, with the rates reaching 30 percent for Blacks and Hispanics.

In addition to the broad impact of this situation on all citizens, organized companies and others that provide health care protection are being penalized. Employers who offer health care benefits to workers are subsidizing employers who refuse to do their fair share. In competitive bidding situations, common in the construction and service industries, companies that offer health care protection are disadvantaged because they are competing with companies that have substantially lower labor costs because they do not offer health care protection.

This legislation calls on Congress to level the playing field. It does not require employers to offer Cadillac plans, merely a package of benefits which are the absolute minimum employees will need to provide for their health care needs and/or those of their families. In collective bargaining our unions will attempt to improve upon these benefits, just as we have attempted to improve on the minimum wage.

Labor unions have become quite concerned about the short- and long-term impact of the growing number of people without access to health care protection. Last August, the AFL-CIO Executive Council passed a resolution calling for public and private sector action to address this problem. In the Fall, we convened a special task force composed of representatives from all of the major segments within the Federation to recommend specific solutions. The recommendations of this task force are embodied in a statement passed by the AFL-CIO Executive Council in February, calling on Congress to require all employers to provide health care coverage. Both statements are attached.

The Federation has also noted the specific problems smaller employers have in obtaining insurance: higher premium costs, higher fixed costs associated with choosing and administering a health plan, and for unincorporated businesses an inequity with respect to the tax treatment of contributions towards employee health insurance. Since 62 percent of small employers not offering health insurance cite premium cost as the primary reason for not offering protection, we believe that your legislation will go a long way towards solving this problem, as well as the others mentioned above.

Presently, there are virtually no insurance products available which would match the benefits in your legislation or facilitate pooling for purposes of achieving the economies that would result from employers being allowed to purchase insurance through regional plans. In addition, we would recommend that serious consideration be given to allowing unincorporated businesses to take a tax deduction for the full amount of contributions towards health insurance plans.

We commend you, Mr. Chairman, for recognizing the special problems of low-waged workers and urge you and the committee to consider waiving the requirement that all other workers contribute up to 20 percent of the premium cost for the minimum benefit package. Currently, the legislation requires deductibles and co-payments that could reach $3,000 per individual before the catastrophic benefit protection becomes effective. We believe that these out-of-pocket requirements are very high. If lower-waged workers also are required to share in the cost of the plan's premiums, despite the availability of insurance protection, they will not be able to afford to take advantage of it.

By requiring all employers to provide a minimum benefit package for both full-time and part-time workers and their families, your legislation removes the incentive some employers might have had to downgrade full-time workers to part- time status. By requiring employers to contribute a per capita payment for health care protection that is not contingent on family status, you have removed the incentive to discriminate against workers with families. We support your effort to make the package adequate to meet basic health care needs, especially pregnancy related services, and although in collective bargaining we would attempt to add other categories of services, we support your effort to keep the cost of the package low.

We strongly support the legislation's preemption provision. In recent years there have been more than 200 state laws passed requiring insured plans to offer certain benefits or reimburse specific providers. Frequently, such benefits, however meritorious in nature, are not the ones that our members either want or need. In most cases, state mandates have been passed in response to vigorous lobbying campaigns by health care providers. You will most certainly face criticism from these groups for taking the position you have. We hope that you and your colleagues will recognize the government's proper role in this area and will leave the question of additional benefits to labor-management negotiations.

Mr. Chairman, before concluding our statement we would like to make some general remarks about the access issue and the role of government in addressing this problem. If passed, S. 1265 will go a long way toward improving the access situation. Nevertheless, several key problems will remain. Individuals who do not work the required number of hours, move in and out of the workforce, are laid off, retire early, or have been labeled "medically uninsurable" will still remain unprotected.

Organized labor urges you to examine the existing patchwork Medicaid system and allow individuals who have incomes under the federal poverty line or who are unemployed to qualify for benefits. We also urge you to consider requiring all states to establish pools through which the medically uninsurable can obtain protection, or to establish separate regional pools for this purpose. Finally, we urge you to allow early retirees to purchase, through the regional plans, the minimum benefit package described in your bill. Otherwise, those without employer-provided health care benefits will continue to remain outside of the health care system.

Mr. Chairman, we are prepared to work with you and your staff to identify the various segments of the uninsured population and develop public and private strategies targeted to their specific needs.

Statement by the AFL-CIO Executive Council

on

Access to Health Care

August 7, 1986
Chicago, IL

Today, 35 million Americans have no health insurance and 50 million have inadequate protection. Among industrialized countries, only South Africa and the United States are without a national health care program.

The goal of organized labor continues to be passage of national health care legislation. Meanwhile, unions are working at the bargaining table to maintain and improve the employment-based health care system they created to protect workers and their families. We have worked for passage of Medicare and Medicaid, which provide coverage for seniors, the severely disabled and the poor who remain outside of the employment-based system.

In recent years, several developments have underscored the inability of our country's patchwork health insurance system to assure all Americans access to health care.

There have been major structural changes in the economy, such as the decline in employment in manufacturing and other basic industries, the creation of new jobs in the service sector, the increase of part-time workers and the expansion of contractual employment. The net effect of these shifts in the economy has been to leave millions of workers and their families with inadequate protection or no health insurance at all. In fact, workers and their dependents constitute two-thirds of the uninsured.

In addition, cutbacks in public programs, efforts by employers to reduce health insurance coverage for current employees, chronic large-scale joblessness and the lack of Medicare coverage for early retirees have greatly increased the number without health care coverage.

The expanding number of uninsured and underinsured are even more at risk in securing health services than in the past, because sharp competition among health providers has reduced the ability of hospitals to spread the costs of charity care among insured groups.

Declining access to care has reached critical proportions. It is a multifaceted problem which calls for both private and public action.

We continue to believe that the best medicine for the overall problem would be the enactment of a national health care system, and we will continue to work for legislation which would make access to basic health care services a right for all Americans.

Unions will continue to fight through collective bargaining and legislation for employer-paid insurance coverage. At the same time, we will expand our cooperative efforts with employers to manage health costs.

We will support federal legislation that extends health care coverage to the unemployed, the uninsured and underinsured and individuals who are denied coverage because they are chronically ill or at high risk of becoming ill.

We will also support Medicare improvements that would limit the amount that Medicare beneficiaries must pay and would extend coverage to include prescription drugs and other items important to the elderly.

Legislation is also needed to extend Medicaid coverage to all individuals and families in poverty.

In recent years, several states have developed programs to expand access to medical care. Such state laws include: broadening Medicaid coverage, funding uncompensated care in cost containment systems, providing funds for charity care, and establishing insurance pools for those who have been denied insurance because of chronic bad health. We urge all states to adopt these measures.

States should also develop pooling programs for small employers, which would reduce premiums and administrative costs.

The AFL-CIO also supports efforts by states to provide operating and capital funds to health care facilities, especially public hospitals, which give a disproportionate share of the care to the uninsured and underinsured.

Finally, we urge immediate steps at all levels to develop an available and affordable system of long-term care for the chronically ill, in the home when appropriate and in nursing homes when necessary.

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Background Paper/Access to Health Care

AFL-CIO BACKGROUND PAPER

ON

ACCESS TO HEALTH CARE

STATEMENT OF THE PROBLEM

Reversing over 40 years of progress towards a more comprehensive network of health coverage, recent employer reductions in private insurance and government cutbacks in public insurance (Medicare and Medicaid) have left a shocking one out of six people--over 35 million Americans--under the age of 65 without insurance today.

The number of U.S. citizens currently without health coverage is 50 percent higher than it was five years ago. And researchers cite perhaps another 50 million with inadequate protection, bringing the current total of uninsured and underinsured Americans to one in four.

Looking closely at the problem of access reveals especially disturbing characteristics of the trend. Two-thirds of the uninsured are workers or dependents of workers. Children are, perhaps, the most vulnerable victims of the collapse of employment-based health insurance. In all, at least one in five children are uninsured.

Reasons for the Growth in the Uninsured Population

Six basic forces have each contributed to the dramatic increase of the uninsured in the 1980s.

* Cutbacks in private health insurance: Employers of all types--including highly profitable ones--are retreating from their historic commitment of providing health benefits for employees. Cuts range from introduction of high deductibles, co-payments and premium sharing, to elimination of insurance altogether. One prevalent practice is to encourage workers to drop insurance when their spouse is employed and covered elsewhere, thus shifting premium costs to another employer. Some employers have withdrawn dependent coverage. Smaller employers, self-employed groups, and even large corporations often provide no health benefits whatsoever. As a result, private insurance now pays for a smaller portion of hospital costs than it did in 1980.

* Changes in the labor market: In recent years there have been major structural changes in the U.S. labor market. A decline in employment in manufacturing and other basic industries where workers have had broad health insurance protection has been coupled with a growth in the number of service jobs, for which wages are low and benefits are either unavailable or totally inadequate. The net effect of these shifts in the economy has been to leave millions of workers and their families without coverage or with minimal protection.

* Unemployment: Continued high unemployment levels since the recession of the early 1980s have left many workers without private insurance yet ineligible for public insurance because of the uneven criteria states use to determine Medicaid eligibility.

- Medicaid cuts: Major federal Medicaid cuts have undermined states' ability and willingness to maintain or improve Medicaid coverage. Today Medicaid covers fewer people than it did in 1976, despite population growth and a massive increase in the poverty population. As a result, Medicaid now covers only 46 percent of all poor families compared to nearly two-thirds in 1975-76. Substandard welfare programs in some states leave most low-income families without coverage. In fact, today Medicaid is more a program for the aged and disabled than a safety net for low-income families--over 70 percent of all Medicaid expenditures pays for retirees and disabled care, especially for care in nursing homes.

- Medicare cuts: A steady erosion of Medicare benefits has left people 65 and over with less and less coverage. Today Medicare pays under half of the cost of care for senior citizens and the severely disabled.

- High health risk: Insurance companies have made it increasingly difficult for small groups or individuals to obtain insurance if their health conditions require high-cost treatment. As a result, many people fall into an "uninsurable" category, yet cannot qualify for existing public programs.

Paying for Care for the Uninsured

When uninsured families get sick, with the usual exception of life-threatening emergencies, they find many hospitals and physicians unwilling to provide care or cutting back on services previously rendered. As the number of uninsured patients increases, so does the cost of providing their care.

Hospitals currently estimate some $6 billion in expenses for uninsured patients--double those of four years earlier. A small percent of hospitals, primarily public facilties, provide a disproportionate amount of this care.

Traditionally, hospitals could partially cover the costs of treating the uninsured by "cross-subsidizing" care. By charging insured patients more, providers were able to defray the cost of care to the uninsured.

Today, in addition to rising numbers of uninsured, two trends serve to undercut this indirect approach to paying for care:

- Public (particularly Medicare) and private insurers are cutting payments to health care facilities to the bone, with no allowance for cross-subsidies for the uninsured.

- Sharper competition among providers and the growth of for-profit hospital and nursing home chains have resulted in some hospitals and physicians refusing to provide care to individuals without insurance and scrambling to shift uninsured patients to some other provider. Obtaining a new contract with a privately-insured group or retaining an existing profit margin often depends on the hospital's ability to close its doors to uninsured patients.

As a result, public hospitals and some non-public inner city hospitals face a looming financial crisis as they take on a growing share of the burden of care for the uninsured. Many of these facilities are now in financial jeopardy.

Human Consequences

The United States has one of the most expensive and extensive health care systems in the world. But without private health insurance or public program coverage, the uninsured find their access to this system severely restricted. They must rely on charity or subsidies from the insured population or go without needed care. With health care competition limiting the ability of providers to shift the costs of treating the uninsured to those with health care protection, lack of insurance today means unnecessary pain and suffering.

Jobless workers, individuals ineligible for public programs and working families without insurance protection postpone seeking care until conditions have reached near critical stages. The following facts illustrate the direct effects of this problem:

* Infant death rates, which are up for the first time in 8 years, have registered the largest increase in 18 years. The United States now ranks 15th in the world in terms of infant mortality, with black infant death rates running twice that of whites.

* There are increasing media accounts of people who have died when lack of coverage has forced them to put off care until it was too late.

* At public clinics and hospitals, lines stretch around the block and ambulances line up at emergency rooms. At the same time, these facilities are cutting staff, freezing wages and postponing needed repairs in an effort to meet new demands with reduced funds.

In short, for a health system built on the assumption that working Americans would have access to employment-based health coverage and that seniors, the disabled and the poor would be covered by public programs, the growing ranks of the uninsured and underinsured exposes a disastrous deterioration of traditional standards.

LABOR'S ROLE IN EXPANDING ACCESS TO HEALTH CARE

The labor movement historically has been the major force in the United States pressing to develop a viable health system in which all could participate. Union demands for decent health benefits have been on the table in nearly every collective bargaining negotiation. Workers and their unions have succeeded in making provision of health benefits part of an employer's basic social responsibility.

Labor sparked coalition efforts to put national health insurance on the legislative agenda, which received serious consideration as recently as the late 1970s.

Recently, with major employers refusing to provide coverage--despite their ability to pay--labor and other concerned citizens have renewed demands for legislative action to make care affordable and accessible. Coalition efforts won victories in 1985 and 1986 in stopping the taxation of fringe benefits and requiring employers to offer continuation and conversion of health insurance at group rates when workers are laid off and lose their eligiblity for health care coverage.

Intense political pressure also succeeded in getting legislation for health insurance for the unemployed out of the House, only to stall in the Senate.

Unions have also worked to preserve a public role and responsibility in the health system. Recognizing the financial needs of public and inner city hospitals serving large numbers of the uninsured, labor pressed for and won some help with special add-ons to Medicare payments to these hospitals.

Finally, labor joined with senior citizens and others to fend off cuts in Medicare and Medicaid demanded by the Reagan Administration.

MULTIPLE SOLUTIONS AND SWEEPING ACTION NEEDED

The remainder of the 1980s and the 1990s will require more sweeping action to address the multiple causes and severe consequences of lack of health care coverage.

We cannot afford to wait.

Until the U.S. has a comprehensive national health care program, the AFL-CIO does not believe any single plan or program can meet the needs of individuals without health insurance protection or those with inadequate coverage. Instead, we propose a multi-pronged approach to a multi-faceted problem. The complexity and diverse nature of the problem requires a public-private sector strategy.

We strongly oppose the views of those who claim that the access problem can be solved through a competitive health care market. Rather, the weight of evidence indicates that the crisis with respect to access has resulted in part from purchasers seeking maximum discounts from providers and refusing to continue, as in the past, to subsidize the cost of care for the uninsured and underinsured.

The AFL-CIO believes that all employers, within the limits of their financial resources, should provide health care coverage to their employees and their dependents; insurers should be prevented from discriminating against individuals with prior or anticipated medical problems; and providers should be prohibited from refusing to treat the uninsured or "dumping" them on public hospitals or other providers currently providing a disproportionate share of care that is uncompensated (i.e., not directly paid for by a private or public program).

Some employers, insurers and providers will not on their own adequately meet their obligations in this area. Therefore, we support legislative action which would ensure that individuals will not go without health care protection as a result of where they work, their prior health care history or their financial means.

The federal government has a special responsibility to ensure that the health care programs it administers, such as Medicare and Medicaid, adequately meet the health care needs of their beneficiaries. In addition, the federal government has an important leadership role to play in developing performance standards for states to meet in establishing programs to directly improve access to care for those who move in and out of the workforce, the long-term unemployed, early retirees and others who may not be eligible for health insurance benefits.

States also have an important role to play. Until most employers are required to provide health insurance coverage and the necessary resources are provided enabling public programs to fulfill their missions, there will be large numbers of individuals who will remain unprotected, inadequately insured and often in need of charity care. The AFL-CIO calls on states to design systems to equitably distribute among providers and purchasers the cost of meeting this obligation as well as to allocate funds directly for these purposes.

Private Sector Responsibilities

A. Employers

Two-thirds of those who are uninsured are workers or their families. Organized labor, therefore, believes that employers who are determined to have adequate financial resources should be required to offer basic health insurance coverage to their employees. Those employers who fail to do so on a voluntary basis should be required to do so by law.

In addition, the special problems that small employers face in purchasing health insurance coverage and administering health benefits have to be recognized. We support the development of multiple employer plans in which a number of small employers join together to purchase coverage, thereby spreading the risk and administrative costs of health insurance over a broader employer base. We also support the development of state insurance pools to reduce the cost of insurance for these employers by spreading the risk over an even larger employer group. States could decide to contribute to such pools by taking on the administrative tasks involved in all or some of the following: choosing carriers, marketing plans and processing claims.

Finally, we support giving sole proprietors and partnerships the same tax benefits for employer-financed health insurance to which corporations that offer health insurance to employees are entitled, provided the non-corporate firms provide the same level of benefits to the proprietors and their employees.

B. Insurers

In 41 states, individuals with poor health care histories are unable to purchase health insurance protection. In other states, an effort has been made to meet this problem by establishing insurance pools through which individuals who are considered to be medically "uninsurable" can purchase protection. We urge all states to establish such pools. It is estimated that this would benefit approximately 2 million people nationwide.

C. Providers

For some time, many health care providers have not been delivering their fair share of charity care and have "dumped" patients with little or no insurance protection onto financially strapped public hospitals. The AFL-CIO advocates the development of state funds to finance hospital bad debts and charity care and to defray expenses incurred by facilities providing a disproportionate share of health care for the uninsured and underinsured.

In addition, although P.L. 99-272 signed on April 7, 1986, contains general language limiting hospitals' ability to transfer indigent patients to other facilities, we urge states to pass legislation strengthening this law by prohibiting all appropriate facilities licensed in a state from denying service to any individual in need of emergency treatment or from allowing the provision of service to be affected by race, ethnicity, religion, age, sex, pre-existing conditions, handicaps, insurance status or ability to pay for services. We also advocate tightening the federal standards for situations where persons with an emergency condition may be transferred from one hospital to another. Such standards should include obtaining the prior consent of hospitals receiving transferred patients, utilization of appropriate personnel and equipment in the transfer, and requiring that patients' records accompany their transfer.

Public Sector Responsibilities

A. The Federal Government

Just as the unwillingness of private purchasers to subsidize the cost of caring for the medically indigent has exacerbated problems associated with funding uncompensated care, recent cutbacks in federal programs, and their failure to keep pace with the needs of beneficiaries, have contributed to the number of individuals with little or inadequate health care coverage.

1. Medicare

Now three years old, the Medicare prospective payment system (PPS) has helped the federal government hold down program expenditures. Because its payment to hospitals is based on the "average" cost associated with caring for certain diagnoses, there is strong evidence suggesting that Medicare does not pay its fair share of the cost of caring for beneficiaries who are extremely ill and in need of more intensive medical care.

Congressional investigations have found that many patients are being discharged from hospitals "quicker and sicker," often without provision for follow-up care when they return to their homes.

In addition, Medicare does not provide catastrophic protection to the 170,000 beneficiaries with very high expenditures, nor does it adequately cover expenses incurred by beneficiaries for outpatient care. Finally, Medicare does not provide coverage for long-term care. This imposes a financial barrier to needed services for the many elderly and severely disabled who do not qualify for Medicaid but do not have the resources to pay out-of-pocket for chronic and long-term care.

Organized labor supports efforts to ensure that Medicare pays its fair share of the cost of treating its beneficiaries by raising payments to hospitals for providing services to those in need of relatively intensive treatment, covering the cost of care for patients with very high expenditures by placing a reasonable limit on their out-of-pocket expenses, and providing coverage for long-term care and other essential benefits, such as prescription drugs, eyeglasses and hearing aids not now covered by the program.

2. Medicaid

Cutbacks in Medicaid have reduced the numbers of the poor eligible for coverage as well as the scope of services to which beneficiaries are eligible. The AFL-CIO opposes further cutbacks in benefits. Instead, we support the development of national standards with respect to eligibility and income, assuring beneficiaries in all states adequate health care benefits.

3. Other Legislation

We will support federal legislation that extends health care coverage to the unemployed, the uninsured and underinsured and individuals who are denied coverage because they are chronically ill or at high risk of becoming ill.

B. The States

State government has a pivotal role to play in developing programs to meet the needs of individuals who are not eligible for public programs but do not have private health insurance. Some of these individuals will continue to require charity care or will not be able to cover the full cost of their medical care, resulting in an increase of bad debts to health care providers.

States must develop a mechanism to annually determine what the health care needs of this population are likely to be. Organized labor recommends that states raise revenues to finance uncompensated care in one or more of the following ways:

- Building allowances for bad debt and charity care into state rate-setting systems, designed to hold down payments to health care providers.
- Levying an assessment on hospitals to contribute a percent of their revenues to a state-uncompensated care pool. Funds from the pool then could be distributed back to health care providers based on their relative efforts to treat the medically indigent. Special preferences should be given to public hospitals and others serving a disproportionate share of this population.
- Levying an assessment on employers who, despite their ability to do so, refuse to offer health insurance coverage to their employees.
- Allocating funds for a state pool from state general revenues.

Once states determine how much is needed to adequately meet the needs of the uninsured and raise the required revenue, such funds should be distributed in one or more of the following ways:

* Providing funds directly to health care providers, with provisions made to target the special needs of public hospitals. In addition, there should be strong incentives for facilities to develop linkages to outpatient delivery systems, ensuring that only those individuals judged to be in need of inpatient services are hospitalized.

* Contracting with selected health care providers to provide comprehensive care to the uninsured for a pre-determined price. Providers participating in the program could include one or a combination of the following: public hospitals, HMOs, community health centers and clinics. Special provisions must be incorporated into such arrangements to protect the rights of health care consumers and the quality of care.

* Expanding the current Medicaid program to include the medically indigent. If a state adopts this option, organized labor would strongly oppose any effort to fund such an effort by cutting back eligibility, benefits or provider payments for current beneficiaries.

Another key responsibility for states is to facilitate the development of insurance pools for individuals who because of prior health care history have been unable to purchase insurance. To reduce the cost of insurance for these individuals, states could impose an assessment on net income of insurers and third-party administrators operating in the state or, alternatively, on all employers that directly provide health insurance or self-insure their medical benefits.

The establishment of such a pool would enable many individuals formerly discriminated against to obtain health care coverage.

CONCLUSION

Recent changes in the economy, cutbacks in public and private insurance programs and competition in the health care delivery system have created a national crisis with respect to access to care. One in four Americans are totally uninsured or have health insurance protection that is insufficient to meet their needs.

There is recognition of this problem in all quarters, and various groups, including legislators, public officials, health care providers, employers and insurers, have advanced proposals for health care reform.

We are committed to working with all parties to make access to care a reality for all Americans.

Statement by the AFL-CIO Executive Council
on
Health Care Coverage

February 19, 1987
Bal Harbour, FL

While the United States leads the world in high-technology medical care, too many Americans lack access to even the most basic health care services. Currently, 16 percent of our population, or 37 million people, are uninsured, a 40 percent increase since 1980. Another 50 million have inadequate health insurance protection.

Workers and their families constitute three-quarters of those without coverage and a substantial number of the underinsured. Many employers make matters worse by cutting health benefits, offering inadequate coverage or refusing to provide any health benefits. The refusal of some employers to offer health care protection forces many workers and their families to postpone seeking care until their long-term health or even their lives are in jeopardy.

Most uninsured enter the health care system only through the doors of hospital emergency rooms. In the past, hospitals passed on the cost of their treatment by increasing charges paid by employer health benefit plans. Recently, hospitals have been less willing to shift these costs because of their desire to be more competitive by offering discounts to large health care purchasers. This has reduced the number of plans that absorb the cost of uncompensated care, making it harder for hospitals to pay for care of the uninsured.

The failure of employers to provide health insurance endangers the health of millions of workers and their families. This practice has established an economically inefficient system in which the last and only resort of the uninsured is to be treated in a hospital--the most expensive health care setting--and it has allowed the burden of financing care for the working uninsured to fall disproportionately on companies which provide protection.

We call upon Congress to:

- Require employers, as a condition of doing business, to assure a minimum package of specified health care benefits to all workers and their dependents, including part-time and laid-off workers. Employers could meet the statutory requirements by assuring health care benefit packages generally equivalent to the standards specified in the legislation.
- Provide financial assistance to low-wage employees to assure their health care protection.
- Limit the maximum out-of-pocket employee cost for the basic package.
- Preempt state laws governing insured plans.
- Require states to establish insurance pools through which employers that desire to do so could purchase the federally mandated benefits at an affordable cost.
- Require states to establish a separate pool so that those who, as a result of existing medical conditions or prior health care histories, have been unable to purchase insurance protection can obtain affordable coverage.
- Allow unions in collective bargaining to improve upon the minimum federal requirements.

The AFL-CIO continues to believe that the most effective way of reducing health care costs, improving access and assuring quality would be for Congress to enact a national health care system. In the meantime, we will work for legislation that will assure access to basic health care services for working Americans and their families.

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Fact Sheet on AFL-CIO Proposal to Mandate Employer-Provided Health Care Coverage

FACT SHEET
ON
AFL-CIO PROPOSAL TO MANDATE EMPLOYER-PROVIDED HEALTH CARE COVERAGE

Summary of AFL-CIO Proposal

The AFL-CIO calls upon Congress to pass legislation to provide a minimum package of health care benefits for employees and their dependents.

- Employers would have the option of assuring coverage through their own plans or multi-employer plans, purchasing coverage through an insurance pool which would be established in every state, or buying into the state Medicaid program.
- To retain flexibility for health plans to be designed to meet the special needs or priorities of specific groups, employers could meet the statutory requirements by assuring health care benefit packages that are generally equivalent to the standards specified in the legislation.
- Employers would be required to continue coverage for laid off workers for a specified period of time, which might be set at 4 to 6 months.
- Employers also would be required to assure coverage for part-time employees. There would be special provisions for cyclical industries and individuals working more than one job.
- All employees would participate in a plan.
- Financial assistance would be given to low-wage employees to assure their health care protection.
- Individuals without a direct relationship to the workforce (e.g., the long-term unemployed, early retirees, etc.) would be given the option of purchasing health care coverage directly through insurance pools established in their states.
- States would be required to establish a separate pool through which the so-called "medically uninsurable", those who have been denied coverage due to current medical conditions or prior health care history, could purchase protection.
- Through collective bargaining, unions and employers could improve upon the minimum federal requirements.
- This legislation would preempt existing state laws requiring that insured health plans offer certain benefits or cover of services of particular types of providers. It also would prohibit states from requiring employer-funded plans to offer services beyond those spelled out in the federally mandated package.

Specific Provisions

Coverage: Employers would be required to assure health care coverage to full-time and part-time employees and their dependents. Employers would have the option of assuring coverage through their own plans or multi-employer plans, both of which could assure coverage directly (e.g., through an insurer, by self-insurance or by contracting with a health maintenance organization or a preferred provider organization) or purchasing coverage through a state insurance pool, which would be established in every state. States also could give employers the option of buying into Medicaid to assure the minimum package to their employees. All employees would be covered by health plans or Medicaid, and financial assistance would be given to low-wage employees to assure their health care protection.

Minimum Benefits: The minimum benefit package all employers would be required to assure would include hospital care, physician services, diagnostic tests, pre-natal and post-partum care, well-baby care up to age one, immunizations for children and prescription drugs for chronic conditions. Employers with health benefit packages that are generally equivalent to the minimum benefit package would not have to change those plans to meet the requirements of the legislation.

Co-Payments: There would be a ceiling on deductibles and co-payment requirements imposed on health services as well as a cap on total out-of-pocket payments for covered services.

Cost Containment: To meet the requirements of the federal act all health plans (including those funded through state insurance pools) would be required to have hospital precertification and utilization review programs and require second opinions for designated surgical procedures. All plans also would be required to coordinate the payment of benefits.

Administration: States would be required to establish two separate insurance pools. One pool would make it possible for employers to purchase the basic federally mandated benefit package at a lower rate than they could otherwise obtain on their own in the insurance market. The second pool would offer protection to those, who because of prior health care histories, have been unable to purchase insurance coverage. States would be required to offer a choice of coverage options through their state pools, including at least one managed care plan such as a health maintenance organization or a preferred provider organization. Pricing of each option would be on a community-rated basis. At their option, states could establish a premium for a Medicaid buy-in for acute care services for employer groups.

Federal regulatory uniformity: Existing state laws requiring insured health plans to offer certain benefits or coverage of services of particular types of providers would be preempted. In addition, states would not be allowed to require employer-funded plans to offer benefits beyond those spelled out in the federally mandated package.

Collective Bargaining: Through collective bargaining, unions and employers could improve upon the benefit package, financing requirements and other provisions of the legislation.

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STATEMENT
OF THE
AMERICAN HOSPITAL ASSOCIATION
TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
OF THE
UNITED STATES SENATE
ON
MANDATED EMPLOYER INSURANCE

July 8, 1987

SUMMARY

The American Hospital Association supports, in concept, mandating employer provided health insurance, and we commend Senator Kennedy and this committee for taking the initiative on this issue. But if the government is to adopt the principle that insurance is a condition of doing business, the government also has an obligation to make compliance with the principle a practical reality.

The Minimum Health Benefits for All Workers Act of 1987 (S.1265) provides a good starting point for discussion of a mandated employer insurance policy. But the bill needs to be fine-tuned. In particular:

- **The definition of federally required services inappropriately excludes mental health services. Although we appreciate the committee's effort to contain costs of complying with a mandate, exempting coverage of mental illness is an inappropriate way to accomplish this.**
- **The preemption of state authority to regulate the content of insurance policies is unwise.**
- **The definition of "employer-provided insurance" may go beyond prevailing practice and therefore could raise costs.**
- **The committee should consider additional ways to lessen economic disruption by phasing in mandates and taking into account factors such as employer size.**

- The federally required regional insurer system would involve a preemption of state authority to regulate insurance and a loss of small employer freedom to choose carriers.
- We urge the committee to take additional steps to provide public-sector support for this private-sector initiative to make business compliance with a mandate more feasible.

We look forward to working further with the committee in fine-tuning this proposal.

INTRODUCTION

Medical indigence is a high priority issue for the American Hospital Association, and its 5,600 institutional and 40,000 personal members. AHA believes bold initiatives from the private as well as public sectors are needed. Therefore, we were pleased to testify before this committee on May 19 to lend the AHA's support to the concept of mandated employer insurance and to outline some of the conditions that could make employer mandates a feasible and workable policy. Now that this committee is considering a mandated employer insurance bill (S.1265), we would like to reiterate our support for employer mandates as a policy approach and to discuss the particulars of the bill.

The time has come to make provision of health insurance a condition of doing business. Just as employers must provide a minimum wage and a safe working environment, they also have an obligation to make health insurance available to their employees. We commend Senator Kennedy for placing mandated employer insurance firmly on the national agenda, and we are committed to working with this committee to devise a workable, feasible mandating policy.

If business has an obligation to make insurance available for employees and dependents, government has an obligation to structure and support the mandates so that employers are able to comply. As the AHA discussed in its May 19 testimony, a workable mandating approach would require two things:

- Carefully defined mandates, with a minimum amount of regulatory intrusion required to implement them; and

- Inclusion of three features designed to minimize economic dislocations caused by the mandate:

  -- a widely available, affordable insurance product;

  -- gradual, phased-in mandates; and

  -- significant tax relief and other subsides.

We were pleased to see that the Health Benefits for All Workers Act of 1987 (S.1265) and companion legislation (S.1386) introduced by Senator Kennedy on June 18 included several features along these lines. As it now stands, however, this bill still needs further modification for these two criteria to be met.

THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987

Under the Minimum Health Benefits for All Workers Act of 1987 (S.1265), all employers would be required to insure their full-time employees--those working at least 17-1/2 hours per week--and their families. Employers would pay 80 percent of premium costs for most workers and their families, and 100 percent of the cost for those earning less than $4.19 per hour. All workers and their families would be required to enroll. The bill defines which services would be required in any plan and does not permit states to mandate additional services.

The bill would create a system of six to eight federal health insurance regions, with two to five carriers in each region authorized to offer approved health benefit plans. All businesses not offering insurance two years after enactment of the bill would be required to purchase coverage from one of these regional insurers. All small businesses deciding to change carriers after this two-year period also would be required to use a regional insurer.

The Access to Health Insurance for Self-Insured Individuals Act (S.1386), also introduced by Senator Kennedy, would complement the mandated health benefits bill by enabling owners of small unincorporated businesses to deduct the entire cost of health insurance premiums from their taxes.

UNRESOLVED ISSUES

Definition of Mandates

Defining what type of coverage employers are required to provide employees will be the most important decision affecting the economic feasibility and policy results of any mandated benefit package. The more generous the required package, the greater the potential hardship for business and the greater the risk of closures or employee layoffs. On the other hand, if the minimum package is pared too far, benefits of the law will be largely illusory. The definition of insurance adopted under a mandated employer insurance law must be carefully crafted because the law would affect the content and cost of benefit packages for all businesses, regardless of whether the employer currently is providing health insurance.

We have serious reservations about how this admittedly difficult issue is handled in the present bill. In particular, the definition of required services inappropriately excludes mental health services. In its current form, Sec. 312(a) of S.1265 requires employers to provide coverage for the following:

- Inpatient and outpatient hospital care (other than inpatient or outpatient mental care);
- Inpatient and outpatient physician services (other than mental health services);
- Diagnostic and screening tests; and
- Prenatal and well-baby care.

Although we appreciate the committee's effort to contain costs of complying with a mandate, exempting coverage of mental illness is an inappropriate way to accomplish this. Treatment for mental illness, including substance abuse, can be expensive, but the lack of timely treatment can have even greater human and financial costs for the employee, the employer, and society at large. If the reason for excluding mental health coverage was the perceived difficulty of controlling utilization, the solution is to address the utilization problem directly, not to discriminate against mental illness in designing a minimum benefit package. Similarly the reference to inpatient and outpatient hospital services appears to exclude coverage of acute medical care such as rehabilitation when not provided under the auspices of the hospital. We would welcome the opportunity to work with the committee on these issues.

A related problem concerns the relationship between any new federal mandate and the existing state mandated benefit laws. The potential existence of both a federal mandate and state mandated benefits poses a difficult policy dilemma for two reasons: the cost of compliance and the usurpation of the states' traditional role of regulating insurance. For many businesses, the cost of compliance would escalate beyond their means if states freely add requirements to the federal mandate. On the other hand, if the federal purpose can be otherwise achieved, federal preemption of state mandated benefit laws seems inappropriate because insurance is a traditional area for regulation by states. Furthermore, many states have debated and deliberated at length before deciding what insurance should include. For example, state regulations have been an important way to achieve comparable treatment of mental health and non-mental health benefits. It would be wrong to overturn these state decisions.

It is possible to find an alternative to the federal preemption of state law called for in S.1265. One alternative might be that states be allowed to keep the authority to require all businesses to offer a health insurance package that is richer than the federally required plan. But the states could be required to offer subsidies for employers unable to meet the full cost of providing the additional state mandated benefits.

Minimizing Economic Disruption

In addition to carefully defined employer mandates, any policy requiring employers to provide health insurance must take steps to minimize economic dislocations and facilitate employer compliance. This can best be done by keeping the costs of compliance as low as possible, by phasing mandates in gradually, and by providing significant tax relief and other subsidies. The current bill, particularly when coupled with tax incentives proposed under S.1386, indicates some effort to minimize economic disruption, but more can and should be done.

Definition of "employer-provided insurance." In terms of the burden to employers, the bill goes beyond prevailing practice and particularly beyond prevailing practice for small businesses.

- It would require employers to pay at least 80 percent of the premium for both employees and dependents;
- It would cap the individual deductible at $250 and the family deductible at $500;
- It would limit copayments to 20 percent of expenses; and
- It would cap out-of-pocket expenses at $3,000 for the entire family.

In many respects we would be heartened to see a change in prevailing practice. More than four million uninsured children live with a parent or guardian without coverage. Many, if not most, of these children would be likely to receive coverage under this bill because of the dependent coverage requirement. On the other hand, the high employer share of dependent coverage, coupled with low deductibles and out-of-pocket caps, could raise costs and thereby induce hardship for businesses already insuring their employees, as well as for those beginning coverage as a result of the new law. This, in turn, could discourage employers from hiring workers with families. This issue warrants a closer look.

Phased-in, gradual mandates. One way to lessen economic disruption to employers and employees is to phase mandates in gradually and to peg requirements to factors such as employer size. The committee has made a good start along these lines by permitting new businesses with fewer than 25 employees to offer only catastrophic coverage during the first two years. The committee also made an attempt to lessen the burden on low-income employees (those earning under $4.19 an hour) by requiring employers to pay the full 100 percent of premium costs. We agree that some subsidy may be in order for those below or near the minimum wage, but the committee may wish to reconsider whether the employer is the most appropriate source for such a subsidy.

The committee also may wish to consider other ways to phase-in mandates. For example:

- Large employers or those with higher gross receipts could be phased-in first, and employers facing greater hardships could be brought in last;

- The required employer share of the premium could be phased-in over time and could vary depending on employer size or other factors; and

- The employer share of the premium could vary depending on the average number of hours worked by the employee. This seems to make more sense than the all-or-nothing approach of S.1265, in which employees working 17-1/2 hours a week are insured along with their families, with 80 percent of the premium paid by the employer, whereas those working only 17 hours a week are not offered group coverage.

Administrative mechanism. One important way to keep group insurance costs down is to increase the size of the group and thereby reduce administrative and marketing costs. The bill's mechanism to achieve this goal is a system of six to eight federal health insurance regions, with two to five carriers in each region authorized to offer approved health benefit plans. Each carrier would have to offer at least two indemnity and two managed care plans. For most types of employers, use of these regional insurers would be optional, and coverage could be purchased from any source. Any employer who has not purchased coverage two years after enactment of the bill, however, would be required to purchase coverage from a "regional insurer." Moreover, all small businesses, those with fewer than 25 workers, which decided to change carriers after this two-year period would be required to offer coverage through a "regional insurer."

We have serious reservations about supporting this particular administrative mechanism. It would involve a preemption of state authority to regulate insurance and a loss of small employer freedom to choose carriers, with no discernible public policy gain. There are many possible administrative mechanisms for bringing about economies of scale, and no compelling evidence that the "regional insurer" model would work better than the others.

Under these circumstances, it would be more prudent for the legislation simply to establish guidelines for the creation of state pooling arrangements but to leave design and implementation to the states. For example, some states might wish to use their Medicaid program as the general pool; others might decide to use multiple-employer trusts as the vehicle for combining small businesses into larger groups. A tremendous amount of experimentation along these lines already is going on at the state level, in part under the auspices of the Robert Wood Johnson Foundation Health Care for the Uninsured Program, and we see no reason to stifle this experimentation.

Public-Sector Support. A final way to facilitate employer compliance is by providing public-sector support for this private-sector initiative to make business compliance with the law more feasible. We applaud Senator Kennedy for introducing a companion bill to enable owners of unincorporated small businesses to deduct the full amount of their health insurance costs from federal taxes. Such a step could put small employers on a more equal footing compared to their counterparts in larger businesses and could help make health insurance affordable for many small businessmen and their families. But we urge the committee to consider additional steps. For example:

- For very small businesses or those with very low profit margins, a tax credit would provide stronger incentives than a tax deduction.

- For employers with low-profit levels, however, changes in tax structure alone may not be enough. For these firms, the committee might wish to consider providing partial subsidies. One logical source of financing would be the tax revenues derived from the health insurance provisions in the Tax Reform Act of 1986. (In cases where employers provide a high level of benefits to some employees and less or no benefits to others, the Tax Reform Act calls for inclusion of the "discriminatory excess" in the gross taxable income of the highly compensated employees.)

Finally, it is imperative that the federal government fulfill its own obligations under existing public-sector programs, particularly Medicaid. Of the employed uninsured, three-fourths earn $10,000 a year or less. Depending on their family status, these workers are near or below--some far below--the federal poverty level, yet are not enrolled in Medicaid. Since 1976, Medicaid coverage of the poor has plummeted from 65 percent to 38 percent. Businesses have an obligation to insure their employees, but they should not be required to compensate for the continued erosion in public programs.

CONCLUSION

We strongly support the concept of mandated employer insurance, and recognize that translating this ideal into a workable policy will require considerable time and deliberation. S.1265 provides a good start for this process. We look forward to working further with the committee in fine-tuning the proposal.

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Peter W. Schwartz
Executive Vice President

TESTIMONY FOR THE RECORD
SUBMITTED BY THE AMERICAN SUPPLY ASSOCIATION
TO THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE
JULY 15, 1987

Mr. Chairman. The American Supply Association appreciates this opportunity to express our views on S. 1265. ASA is the national association for wholesaler-distributors of plumbing-heating-cooling-piping products and systems. Of the 4,000 p-h-c-p wholesalers throughout the country, most are small, family-owned businesses, with traditional supply-house operations consisting of anywhere from 15 to 50 employees. Some of our largest members have over 1,000 employees.

Mr. Chairman, we too are alarmed by the health insurance gap in this country. No one should be denied access to health care because they are uninsured. Yet, this is exactly what is happening for millions of Americans. And with rising health care costs, the problem is nearing crisis proportions.

We recognize the enormity of the problem. We are deeply concerned about finding a workable solution. Yet, Mr. Chairman, we will not mince words: ASA strongly disagrees that S. 1265 is the answer. S. 1265 has been described as a simple cure for the problem. Yet, such simplicity can be devastating, leading to even higher health care costs, fewer employment opportunities for those most in need of work and reduced benefits for all employees.

As the debate focuses on the 35 million uninsured workers, we tend to lose sight of the fact that over 130 million Americans now enjoy a high level of quality health care coverage at an affordable price due to the existing voluntary, employer-sponsored health benefits system. This system is strong, it is effective and it should be maintained. While the avowed intent behind S. 1265 is to build on that voluntary system, this proposal would in reality undermine it. This is very disturbing to us. The basis of our voluntary system is its flexibility. It allows health benefits to be tailored to meet the needs and desires of employees in a particular locale, as well to take into account cost and availability factors. It also enables employers and employees to structure health insurance in the context of the employee's entire wage and benefit package.

S. 1265, with its minimum mandates, encourages uniformity while stifling creativity. Moreover, it creates an economic incentive for employers to actually reduce health benefits to the minimum level requirements of S. 1265. After all, why should a company provide a "Cadillac" plan if they have to pay 80% of the plan and provide it to anybody who stays with the company longer than 30 days or helps out on a part-time basis? Many companies, including many of our members, now provide very generous policies, with extensive dental coverage, low deductibles, or disability coverage, for example. These kind of benefits should be encouraged. The net effect of S. 1265, however, would be to downgrade the overall quality of health coverage for a great many workers. Surely there is a way that everyone can be provided with a basic level of health insurance without lowering the level of benefits overall.

S. 1265 has been labelled as a "tax on employment and entrepreneurship."1 And, indeed, it is. Moreover, the cost of this proposal -- which is estimated by the sponsors of the legislation to be $25 billion, while other analyses place the cost closer to $100 billion -- is to be borne by those least able to afford it: small businesses.

During the discussion of S. 1265, small businesses as a whole have at times unfortunately been mistakenly cast as the villain in the problem of the uninsured worker. While it is true that 55% of the very smallest businesses (those with fewer than 10 employees) do not provide health insurance, as a matter of fact, the large majority of small businesses with 10 or more employees presently provide health insurance benefits to their employees.2 Surveys show that in companies with 10 to 24 employees, over 75% offer health benefits to their employees; firms with 25 to 99 employees provide health benefits 90% of the time; and businesses with 100 to 499 employees provide health benefits 98% of the time.3

Yet, if S. 1265 is enacted, the costs to these small businesses -

---

1 "Should All Employers Be Required By Law to Provide Basic Health Insurance Coverage for their Employees and Dependents?" Uwe E. Reinhardt, Ph.D., paper for the Employee Benefit Research Institute policy forum on "Government Mandating of Health, Pension, and other Employee Benefits," April 27, 1987.

2 U.S. SBA, Office of Advocacy, ICF Report, 1986.

3 Ibid.

- those already providing coverage -- will be staggering. By way of example, let me explain to you the typical situation of an ASA member. The vast majority of our members provide health insurance benefits to their employees. In most cases, the level of benefits equals or surpasses the minimum requirements of S. 1265. And, generally, health insurance benefits are not extended to temporary or part-time employees.

If S. 1265 is passed by Congress, our labor costs would be increased substantially. Even though most ASA members would have no trouble meeting the minimum requirements of S. 1265, the employer's share of the premium cost is often less than the 80% required in S. 1265. Normally, around 50% of the premium cost is paid by our member companies. For an employer with 100 employees covered by health insurance, the requirement of S. 1265 to pay 80% of premiums would trigger a yearly increase of roughly $36,000 just for current employees who are already insured!

Second are the increased labor costs stemming from the mandatory duplicate coverage provision. Under S. 1265, every worker is to be insured by their own employer, even if they could be covered by a spouse or parent's plan. This flies in the face of the stated intent, which is to provide basic coverage to everyone. Instead, for many families, business will be providing coverage several times. For example, when you have a family with two income-earning spouses and an 18-year old worker, all three would pay separate premium contributions, as would their employers, for the same basic coverage. Not only is this more costly overall, it also limits the family's choice in selecting optional benefits in cafeteria-style plans. Obviously, under our present voluntary benefits system, when one spouse has health insurance coverage, the other spouse often has the option to choose some other benefit, such as child-care, thus expanding the family's total nonwage compensation. To eliminate or discourage these kind of options will only work to the disadvantage of individual employees.

A third cost is the direct expense of providing health insurance coverage to part-time workers and temporary employees, a cost estimated to be $1200 per year per employee. Like other small businesses, part-time employees are critical to our company. And, with many of our members involved in heating and cooling, use of seasonal workers is often required. In fact, ASA members commonly employ high school students during the summer months, a practice which provides mutual benefit. For us, students offer a ready source of enthusiastic, able workers. At the same time, it gives the youngsters needed income and gives them a taste of what it is like to hold down a job. However, if S. 1265 is passed, this unfortunately would significantly impact our ability to hire summer help. Economically, it would be more practical to contract out the extra work when we need it. What, then, would happen to the young people? And is this the kind of result we want?

By mandating complete health insurance coverage for all part-time or temporary workers, S.1265 ignores the reality of the marketplace. Our obligation to an employee who is with us three months is just not the same as it is for someone who has made a career commitment to the company.

The problem is further compounded when other recent employee mandates are brought into play. Our members are still feeling the sting of the recently enacted COBRA continuation coverage provision (where employers are required to offer those employees, who are already covered by health insurance, continuation of that coverage at employee expense for periods ranging up to three years when they leave the company). Add COBRA to S. 1265 and you have an administrative nightmare for small businesses, who are ill-equipped to handle the paperwork involved in offering continuation coverage to each and every part-time and seasonal worker (and their dependents) who happen to come in and out of the company. Even more frightening is the possibility that Congress might act on existing proposals to require employers to pay for the cost of continuation coverage.

S. 1265 tries hard, but it is not the answer. It is an expensive, inflationary, awkward attempt to solve an urgent social problem. On the one hand, it overreaches:

* intruding on employers already providing quality coverage to their workers, causing a needless

restructuring of the content and design of each employee's wage and benefit plan;

* adding a costly layer of duplication, leading not only to higher health care costs, but limiting the employee's choice of nonwage benefits, as well;

* placing the financial responsibility for a stubborn socioeconomic problem squarely on the backs of small business.

On the other hand, it does not do the job it claims to do: more than a third of current uninsured individuals will still be without health insurance.

The approach taken to solve the problem of uninsured Americans should not result in double coverage for some families and it should not penalize those businesses already providing health insurance to their employees. Nor should it serve to encourage companies to reduce the level of benefits they are already providing to their employees. One way to avoid these undesirable consequences would be to permit current employees, who are already providing health insurance benefits, to obtain a waiver, exempting them from the provisions of S. 1265, as long as they continue to provide the current or similar coverage. This would ensure that employers who are not part of the problem are not penalized, nor encouraged to reduce benefits to the minimum level.

Mr. Chairman, ASA stands ready to work with the committee to explore other avenues to address this most serious problem.

American
Psychiatric
Association

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July 9, 1987

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
113 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Kennedy:

On behalf of the American Psychiatric Association, a medical specialty society representing over 33,000 psychiatrists nationwide, we appreciate the opportunity to comment on the Minimum Health Benefits for All Workers Act of 1987 (S. 1265)and have our remarks included in the hearing record.

As a medical society comprised of psychiatric physicians devoted to the caring of mental and physical well being we can appreciate the intent of the bill and the importance of assuring health care for those 24 million employed Americans currently without insurance coverage. We cannot, however support the concept of a bill which specifically excludes treatment for mental illness and simultaneously preempts existing state mental health mandate laws. This reverses the progress that 29 states have made in the last 20 years in developing mandated mental health insurance benefit laws. By excluding coverage for mental illness it ignores all the recent research regarding the efficacy of early diagnosis and treatment of mental illness and negates the efforts of mental health advocates to provide even minimal coverage to the socially disenfranchised mentally ill citizens of our nation. Once again, the mentally ill would be left to their own devices, denied employment, shunted aside and abandoned.

For centuries the mentally ill were ostracized from society and relegated to second class treatment. Years of research and extraordinary progress into the etiology and treatment of mental illness and the tireless work of families and advocates for the mentally ill is just beginning to be successful in educating the public to the needs and treatability of the mentally ill. Within the past few years exciting new breakthroughs in the treatment of mental illness have significantly changed not only our understanding of the causes of mental disorders, but have also given us the ability to effictively treat such disorders. For example, through recent research we have attained the capacity to effectively treat more than 85% of all severe depressions using drugs and psychotherapies. We have verified the existence of a genetic component to psychoses, and determined that envionmmental events may trigger one's inherited risk of predisposition for a given disorder. We have also refined techniques for diagnosing mental illness, which permits treatments to be tailored specifically to a patient's needs and ensure comparability of results in clinical research. Finally, we have gained a capacity, through techniques such as positron emission tomography and nuclear magnetic resonance, to observe biochemical activity in the conscious brain, and define discrete areas of the brain that may be defective in certain illnesses.

Although there have been tremendous advances in the diagnosis and treatment of mental illness in recent years, psychiatric benefits under Medicare and private insurance remain in the dark ages. There is a growing awareness and understanding of those in public policy positions, whether state or federal legislatures or insurance companies and they are finally responding. This bill would set all these efforts back twenty years and once again relegate a segment of the population whose only problem is that they are unfortunate enough to suffer a mental rather than a physical illness, to become outcasts of society.

Furthermore, our studies consistently show savings in dollars as well as productivity in providing mental health benefits. Many studies have documented the offset effect — a reduction in health care utilization when mental health services are provided. A recent NIMH study of Aetna Life Insurance Company's claims from 1980-83 for enrollees in the Federal Employee Health Benefits Program compared overall health care service use by those families not using mental health services. Prior to the initiation of mental health treatment, use of overall health serivces rose gradually for three years with a sharp increase during the six months immediately preceding mental health treatment. Once mental health treatment was initiated, overall health use fell.

We understand the current budget constraints and all the competing interests in fashioning such a bill as this but we cannot support this bill in its present form.

We appreciate the opportunity of having our remarks inserted in the record and we look forward to working with your staff in developing a bill that will address both mental and physical illness so that we may lend our support to a bill with good intentions.

Sincerely,

Jay Cutler

Jay B. Cutler
Special Counsel and Director
Division of Government Relations

JBC:PG:rw

STATEMENT
OF THE
ASSOCIATED GENERAL CONTRACTORS OF AMERICA
TO
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
ON S. 1265
"THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987"

AGC is:

- More than 32,500 firms including 8,000 of America's leading general contracting firms responsible for the employment of 3,400,000-plus employees:
- 106 chapters nationwide;
- More than 80% of America's contract construction of commerical buildings, highways, industrial and municipal-utility facilities; and
- Over $100 billion of construction value annually.

June 1987

The Associated General Contractors of America (AGC) is pleased to comment on the Minimum Health Benefits for All Workers Act of 1987 (S. 1265).

S. 1265, if enacted would require that:

- All employers, subject to minimum wage laws under Fair Labor Standards Act, provide minimum health insurance packages to employees and their dependents;

- Health care insurance coverage be provided to all employees working 17 1/2 hours or more per week;

- "Minimum Coverage" under health care insurance include all "medically necessary" hospital care, physician care, diagnostic tests, pre-natal care and well-baby care;

- Health care insurance include $3,000 per year out-of-pocket expense cap (catastrophic protection);

- Employers pay no less than 80 percent of the premiums for employee and dependent coverage; and

- Employee deductibles be limited to $250 per individual and $500 per family.

AGC opposes passage of S. 1265 because existing health care coverage of employees in the construction industry is responsive to employee and employer needs, flexible enough to adopt to changing markets, and designed to reflect the unique nature of the employment relationship in construction.

AGC is opposed to the provisions of S. 1265 for the following reasons:

o The enactment of minimum health care legislation is unnecessary. The Construction Labor Research Council (CLRC) recently conducted a review of health insurance coverage in construction industry collective bargaining agreements. CLRC's data indicated almost universal inclusion of health and welfare programs in the industry. According to CLRC's data 95 percent of all collective bargaining agreements covering 99 percent of union construction workers provide for health care insurance.

Based upon a 1982 survey of open shop contractors, conducted by the Industrial Research Unit of the Wharton School of Business, more than 75% of the firms provided health care insurance coverage for their employees. In the five year period since the survey was conducted there is every reason to assume that higher demand for construction workers has resulted in an increased percentage of health care insurance coverage of employees in the open shop market.

- Construction wage rates and fringe benefit programs, including health care insurance, have been established to address the uniqueness of the construction employment relationship. The construction industry employment relationship is temporary and intermittent and mirrors the construction industry's project-by-project operations. Employees laid-off by one employer, because the project is complete, generally find employment with another employer. Employees may work for several employers during the course of a year.

- The transient and mobile nature of construction operations makes it impossible to know when a former employee is now working on another project for another employer who is also providing health care coverage. Given the high turnover rate in construction, often exceeding 300 percent, the cost of providing health insurance to employees, who have not established a permanent attachment to an employer, would be a tremendous burden on employer sponsored health care insurance programs.

- The costs of implementing the provisions of S. 1265 would be astronomical in the construction industry, due to duplicate coverage, coverage of part time workers and plan conformance to arbitrarily established benefit levels. The result will be increased health care insurance costs with little, if any, benefit for the vast majority of construction employees currently covered by health care insurance.

- The proposed "minimum" health benefits contained in S. 1265 are very similar to the health benefits offered through plans maintained by many of this country's largest employers. These "minimum" proposals are especially inequitable and expensive for the small and moderate-sized businesses in the construction industry. Small construction businesses simply cannot afford the added burden of providing a generous array of health care benefits.

- The requirements of S. 1265 will also prohibit employers from modifying plan design to fit the nature of the employer/employee relationship in the construction industry or of geographical location. In the construction industry for example, extended coverage during periods of unemployment may be more important than "deductible" levels. A $500 per family deductible may be appropriate in certain areas of the country but unrealistic in another part of the country. In the real world medical costs are not the same in all parts of the country and health care benefits levels and coverage are decisions which the affected parties should make.

AGC supports the present system of voluntary, nondiscriminatory, private sector employee health care benefit plans which vary in accordance with the needs of employers and employees. AGC opposes the imposition on the construction industry of federally-mandated health care insurance.

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WRITTEN STATEMENT

FOR THE RECORD

S. 1265

U.S. SENATE

LABOR AND HUMAN RESOURCES COMMITTEE

U.S. SENATOR EDWARD M. KENNEDY, CHAIRMAN

Presented by:

Aaron K. Trippler
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SENATOR KENNEDY AND MEMBERS OF THE COMMITTEE:

MY NAME IS AARON TRIPPLER AND I AM VICE PRESIDENT OF PUBLIC AFFAIRS FOR COMMUNICATING FOR AGRICULTURE. I APPRECIATE THE OPPORTUNITY TO PROVIDE A WRITTEN STATEMENT FOR THIS COMMITTEE ON SENATE 1265 REQUIRING THAT ALL EMPLOYERS PROVIDE HEALTH INSURANCE TO THEIR WORKERS.

I WOULD LIKE TO TAKE THIS OPPORTUNITY, SENATOR KENNEDY, TO THANK YOU FOR YOUR CONCERN AND LEADERSHIP ON BEHALF OF THE MILLIONS OF AMERICANS, IN BOTH URBAN AND RURAL AMERICA, CURRENTLY DENIED THE OPPORTUNITY FOR ADEQUATE HEALTH INSURANCE PROTECTION. YOUR LEADERSHIP IN INTRODUCING THIS LEGISLATION IS A CRITICAL ONE IF WE ARE TO BEGIN SOLVING SOME OF TODAY'S HEALTH CARE PROBLEMS. WE APPLAUD YOUR EFFORTS AND THANK YOU FOR CARING.

COMMUNICATING FOR AGRICULTURE, WITH NATIONAL HEADQUARTERS LOCATED IN MINNESOTA, IS A NATIONAL, NONPROFIT, NONPARTISAN ORGANIZATION DEDICATED TO PRESERVING AND STRENGTHENING THE RURAL WAY OF LIFE. OUR MEMBERSHIP IS

COMPOSED OF FARM AND RANCH FAMILIES AND SMALL AGRI-BUSINESSES IN OVER FORTY STATES. WE CONSIDER OURSELVES IN ADDITION TO, NOT IN PLACE OF, ANY OTHER RURAL ORGANIZATION AND WORK TO ACCOMPLISH OUR GOALS IN A POSITIVE WAY.

CA STRONGLY BELIEVES IN THE IMPORTANCE OF PRIVATE HEALTH CARE AND INSURANCE SYSTEMS. THIS IMPORTANCE WAS REFLECTED IN CA'S FIRST MEMBER-ADOPTED RESOLUTION, AND REAFFIRMED EACH YEAR SINCE, THAT STATES IN PART, "HEALTH CARE AND HEALTH INSURANCE ARE BEST ADMINISTERED AND MAINTAINED BY THE PRIVATE SECTOR, WITH A MINIMUM OF GOVERNMENT INTERFERENCE AND WITH LEGISLATION ENACTED ONLY TO INSURE THAT ALL AMERICANS ARE GUARANTEED A MINIMUM STANDARD OF HEALTH INSURANCE AT A REASONABLE COST, REGARDLESS OF HEALTH OR AGE,..."

CA HAS NOT SAT IDLY BY CONCERNING THIS RESOLUTION. SINCE 1976, WE HAVE WORKED HARD TO ASSIST STATES IN ADOPTING COMPREHENSIVE HEALTH INSURANCE PLANS FOR HIGH RISK INDIVIDUALS, COMMONLY REFERRED TO AS RISK POOLS.

WHILE NOT USUALLY AN ORGANIZATION TO DWELL UPON ITS SUCCESS, BUT RATHER WORK ON SOLUTIONS TO NEW AND ON-GOING PROBLEMS, WE BELIEVE NO OTHER ORGANIZATION HAS WORKED

HARDER ON RISK POOLS THAN CA, AND BELIEVE OUR EFFORTS IN THIS AREA ARE TRULY NOTEWORTHY.

SINCE THE FIRST TWO RISK POOLS WERE ADOPTED IN 1976, TWELVE ADDITIONAL STATES HAVE ADOPTED THE PROGRAM. FOUR OF THESE STATES PASSED THE LEGISLATION EARLIER THIS YEAR AND A TOTAL OF EIGHT STATES HAVE ADOPTED THE PROGRAM WITHIN THE LAST THREE YEARS. LEGISLATION WAS ALSO INTRODUCED IN ANOTHER TWELVE STATES IN 1987.

WHILE FOURTEEN STATES HAVE IMPLEMENTED THESE PROGRAMS, WE REALIZE WE HAVE A LONG WAY TO GO BEFORE WE HAVE A POOL IN EVERY STATE. BUT IT IS ALSO A GREAT FEELING TO KNOW WE HAVE WORKED TO PROVIDE ACCESS TO HEALTH INSURANCE FOR OVER 60 MILLION AMERICANS LIVING IN THESE 14 STATES.

YET, RISK POOLS HAVE THEIR LIMITATIONS. THEY ARE ONLY AVAILABLE TO THOSE INDIVIDUALS WITH THE INCOME OR RESOURCES TO PURCHASE THE COVERAGE, NORMALLY CHARGING PREMIUMS OF APPROXIMATELY 25 TO 50 PERCENT HIGHER THAN THOSE OF A STANDARD RISK. IN ADDITION, THE QUESTION OF FUNDING THE LOSSES OF THE POOL HAS CREATED MAJOR OBSTACLES TO MORE PLANS. STATES MUST EITHER FUND THE POOL LOSSES DIRECTLY FROM GENERAL REVENUE OR DEVISE A FAIR AND ADEQUATE SYSTEM

OF ASSESSING THESE LOSSES ON PRIVATE INSURANCE CARRIERS, SELF-FUNDED PLANS, EMPLOYERS, OR HOSPITALS.

CONGRESS HAS WORKED VERY HARD DURING THE PAST COUPLE OF YEARS TO SOLVE THE PROBLEM OF HEALTH INSURANCE AVAILABILITY. WHILE YOUR EFFORTS DID NOT RESULT IN LEGISLATION SPECIFICALLY ADDRESSING HEALTH INSURANCE POOLS, THE STATES HAVE LEARNED OF YOUR EFFORTS. THIS HAS BEEN REFLECTED IN THE INCREASED EFFORT BY STATES TO ADDRESS THE GROWING PROBLEM OF THE UNINSURED.

SENATOR KENNEDY, I BELIEVE THAT CA IS ONE OF THE ONLY RURAL ORGANIZATIONS IN AMERICA HEAVILY INVOLVED IN THE HEALTH CARE FIELD. WE TAKE PRIDE IN THIS INVOLVEMENT, IN OUR PAST SUCCESS, AND HOPE TO DO MUCH MORE IN THE FUTURE.

THIS CONCERN AND INVOLVEMENT DIRECTLY PERTAINS TO YOUR BILL, S. 1265, BEING HEARD BEFORE THIS COMMITTEE. I WOULD HOPE THAT YOU MIGHT SERIOUSLY CONSIDER OUR RECOMMENDATIONS ON THIS ISSUE.

AS STATED EARLIER, A MAJORITY OF OUR MEMBERS ARE SELF-EMPLOYED INDIVIDUALS. AS SUCH, THEY DO NOT QUALIFY FOR GROUP INSURANCE COVERAGE SUCH AS THAT PROVIDED BY

EMPLOYER-EMPLOYEE GROUPS. THEIR INSURANCE IS PURCHASED INDIVIDUALLY OR THROUGH ASSOCIATION GROUPS, WHERE UNDERWRITING IS USUALLY REQUIRED. IF THEY HAVE A PRE-EXISTING HEALTH CONDITION, COVERAGE IS USUALLY DENIED. RISK POOLS HELP SOLVE THIS PROBLEM.

CA IS STILL UNCLEAR AS TO THE EFFECT THAT S. 1265 WOULD HAVE ON THE SELF-EMPLOYED. WE HOPE THE LEGISLATION'S INTENT IS TO ALLOW THESE INDIVIDUALS THE SAME ACCESS TO HEALTH CARE, REGARDLESS OF THEIR HEALTH CONDITION, AT A REASONABLE PREMIUM, THE SAME AS RISK POOLS PROVIDE NOW.

MANY OF THE SELF-EMPLOYED IN RURAL AMERICA ARE DROPPING THEIR HEALTH CARE COVERAGE DUE TO THE RURAL ECONOMY. AS SUCH, MANY ARE HAVING TO LOCATE FULL-TIME OFF-THE-FARM JOBS FOR THEMSELVES OR THEIR SPOUSES TO SUPPLEMENT THIS LOST INCOME. WHEN S. 1265 PASSES, THESE INDIVIDUALS WOULD BE ASSURED ADEQUATE HEALTH PROTECTION UNTIL SUCH TIME AS THEY RETURN TO THEIR FULL-TIME FARMING OPERATION. I CAN ASSURE YOU, SENATOR, THAT RURAL AMERICA IS COMPOSED OF VERY INDEPENDENT PEOPLE WHO WANT TO REMAIN IN THEIR CHOSEN OCCUPATION, STAND ON THEIR OWN TWO FEET, AND TAKE CARE OF THEIR OWN HEALTH CARE COVERAGE.

ALONG THIS VEIN, COMMUNICATING FOR AGRICULTURE SUPPORTS THE CONCEPT OF REQUIRING THAT ALL EMPLOYERS PROVIDE HEALTH INSURANCE TO THEIR WORKERS AND DEPENDENTS.

IN ADDRESSING CA'S CONCERNS WITH S. 1265, WE FEEL THE BILL WOULD BE FAIRER TO ALL IF THE DEFINITION OF EMPLOYEE WERE EXPANDED. THIS RECOMMENDATION WOULD COVER A BROADER AREA THAN IS CURRENTLY DEFINED.

CA FEELS AN EMPLOYEE SHOULD BE DEFINED AS ONE WHO WORKS AT LEAST 30 HOURS PER WEEK RATHER THAN 17 1/2. IN ADDITION, THERE SHOULD BE A PRE-EXISTING CONDITION CLAUSE OF APPROXIMATELY 90 DAYS BEFORE COVERAGE TAKES EFFECT IF THE EMPLOYEE HAD NO PREVIOUS HEALTH CARE COVERAGE. IF THE EMPLOYEE IS MOVING FROM ONE PLAN TO ANOTHER, THE CURRENT WAITING PERIOD OF 30 DAYS IS SUFFICIENT.

AS YOU HAVE STATED ON NUMEROUS OCCASIONS SENATOR, S. 1265 IS NOT THE "CADILLAC" OF PLANS. YET, CA IS CONCERNED ABOUT THE MANY PART-TIME WORKERS EMPLOYED FOR SHORT PERIODS OF TIME IN RURAL AMERICA. WE BELIEVE S.1265 WOULD BETTER SERVE THE RURAL SECTOR IF THE DEFINITION WERE TIGHTENED UP SLIGHTLY.

UPON LEAVING A JOB, WE WOULD LIKE TO SEE A CONVERSION OPTION AVAILABLE TO THE EMPLOYEE, ALLOWING HIM/HER TO CONTINUE THE SAME COVERAGE FOR UP TO SIX MONTHS BY PAYING THE SAME PREMIUM AS THAT PAID BY THE EMPLOYER. THIS PROVISION WOULD ASSURE AN INDIVIDUAL WITH ADEQUATE COVERAGE SHOULD HE DESIRE TO TERMINATE HIS EMPLOYMENT. IT PLACES THE PREMIUM RESPONSIBILITY SQUARELY ON THE SHOULDERS OF THE INDIVIDUAL TERMINATING HIS JOB OF HIS OWN FREE WILL.

CONCERNING THE RESPONSIBILITY OF THE INSURANCE INDUSTRY AS A WHOLE, WE ALSO FEEL THAT A LOSS RATIO SHOULD BE BUILT IN TO ASSURE THAT BENEFIT LEVELS ARE SOMEWHAT ALIGNED WITH THE PREMIUM DOLLARS COLLECTED. A LOSS RATIO OF AT LEAST 65 PERCENT, BUT NOT MORE THAN 75 PERCENT, SHOULD BE SUFFICIENT TO ALL PARTIES CONCERNED.

YOUR LIMITATION OF A 20 PERCENT PREMIUM TO BE PAID BY THE EMPLOYEE MAKING MORE THAN MINIMUM WAGE IS COMMENDABLE. IN ORDER TO ASSURE EMPLOYEES AND DEPENDENTS THE SAME BENEFITS, WE WOULD LIKE YOU TO CONSIDER THE POSSIBILITY OF ASKING EMPLOYERS TO PAY THE FULL 100 PERCENT OF THE PREMIUM FOR ALL EMPLOYEES, BUT ALLOWING THE EMPLOYER TO CHARGE UP TO 20 PERCENT OF THE PREMIUM FOR DEPENDENTS IF WAGES PAID ARE ABOVE MINIMUM WAGE. WE BELIEVE THIS WOULD ASSURE ALL

EMPLOYEES EQUAL COVERAGE, YET FORCE THE EMPLOYEE TO ACCEPT MORE RESPONSIBILITY FOR HIS/HER DEPENDENTS.

AT THIS TIME, CA HAS NO RECOMMENDATIONS FOR THE OTHER MAJOR SECTIONS OF S. 1265 CONCERNING THE WAGE RATE, REGIONAL INSURER CONCEPT, OUT-OF-POCKET EXPENSES AND WAIVERS. WE WOULD ONLY ADD THAT PERHAPS A HIGHER CHOICE OF DEDUCTIBLES BE OFFERED.

A HIGHER CHOICE OF DEDUCTIBLES SHOULD BE ALLOWED IF BOTH EMPLOYER AND EMPLOYEE SUPPORT THE IDEA. AN EXAMPLE OF WHEN SUCH A DEDUCTIBLE MAY BE ADVANTAGEOUS TO BOTH CAN BEST BE EXPLAINED BY REVIEWING CA'S CURRENT MAJOR MEDICAL GROUP HEALTH PLAN.

CA DESIGNED A PROGRAM WHICH ALLOWS INDIVIDUALS TO CONTROL THEIR OWN HEALTH CARE COSTS AND INVOLVES AN EQUITY FUND APPROACH, THEREBY ALLOWING THE INDIVIDUAL TO RECEIVE A RETURN ON HIS/HER INVESTMENT IN HEALTH INSURANCE COVERAGE, REGARDLESS OF HOW MANY CLAIMS ARE FILED OVER THE LIFE OF THE CONTRACT. IT ALSO ALLOWS THEM TO CHOOSE THEIR OWN DEDUCTIBLES.

UNDER THIS CONCEPT, AN INDIVIDUAL PURCHASES A

CATASTROPHIC HEALTH INSURANCE PLAN WITH A GUARANTEED MONTHLY INCOME RIDER IN ADDITION TO A UNIVERSAL LIFE INSURANCE PLAN WITH DISABILITY WAIVER OF PREMIUM.

THE PLAN PAYS NEARLY ALL HEALTH CLAIMS, SIMILAR TO MANY OTHER HEALTH PLANS. HOWEVER, USING TODAY'S RATES OF APPROXIMATELY $185 PER MONTH FOR A 35-YEAR OLD MALE AND HIS FAMILY, THE PLAN WOULD ALSO PAY DEATH BENEFITS OF $52,710, PAY ALL PREMIUMS IF THE POLICYHOLDER BECOMES DISABLED, PAY PREMIUMS FOR ONE YEAR FOR THE SURVIVING SPOUSE AND FAMILY, OR PROVIDE A MONTHLY INCOME OF OVER $350 PER MONTH SHOULD THE INDIVIDUAL RETIRE AT AGE 65 AND HAVE KEPT THE PLAN IN FORCE.

IN ADDITION, THE PLAN ALLOWS THE INDIVIDUAL TO RAISE THE DEDUCTIBLE PORTION OF THE PLAN WHEN PREMIUMS RISE, THEREBY KEEPING THE MONTHLY PREMIUMS AT THE SAME RATE, YET PLACING MORE DOLLARS IN THE SIDE FUND. SHOULD THE NEED ARISE TO PAY THIS HIGHER DEDUCTIBLE, THE INDIVIDUAL HAS THE OPTION OF DIPPING INTO THE SIDE FUND.

I MIGHT ADD THAT CA IS TOTALLY IN SUPPORT OF YOUR EFFORTS TO INCREASE THE AMOUNT OF TAX DEDUCTIONS ALLOWED FOR THE PURCHASE OF HEALTH INSURANCE COVERAGE BY EMPLOYERS.

IN CLOSING, CA IS IN TOTAL SUPPORT OF THE CONCEPT OF EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH INSURANCE COVERAGE TO ALL EMPLOYEES AND DEPENDENTS. WE HAVE LONG BELIEVED THAT WITHOUT SUCH COVERAGE, WE ALL PAY IN THE LONG RUN THROUGH HIGHER PREMIUMS. YOUR LEGISLATION SQUARELY PUTS THE RESPONSIBILITY ON ALL EMPLOYERS, INCLUDING THOSE IN RURAL AMERICA.

CA AND ITS MEMBERS HAVE ALWAYS BELIEVED THAT ONE OF THE REASONS GOVERNMENT WAS CREATED WAS TO ASSIST CITIZENS IN THOSE AREAS IN WHICH THEY CANNOT HELP THEMSELVES. IT IS OUR BELIEF THAT PASSAGE OF S. 1265, WITH A FEW MODIFICATIONS, GOES A LONG WAY IN ACCOMPLISHING THIS GOAL. S. 1265 ALLOWS THE PRIVATE SECTOR TO ADAPT TO THE RAPID CHANGES TAKING PLACE IN HEALTH CARE, BUT WITH A LITTLE PUSH FROM GOVERNMENT. CA IS OPPOSED TO NATIONAL HEALTH INSURANCE AND BELIEVES S. 1265 IS AN ACCEPTABLE ALTERNATIVE.

NEARLY 37 MILLION CITIZENS IN THIS COUNTRY ARE UNINSURED OR UNDERINSURED. YOUR LEGISLATION IS EXPECTED TO TAKE CARE OF APPROXIMATELY 24 MILLION OF THESE INDIVIDUALS. CA BELIEVES THAT RISK POOLS WILL HELP ANOTHER ONE TO TWO MILLION. WE HAVEN'T FOUND THE ANSWERS FOR EVERYONE, BUT NO ONE

SOLUTION WILL WORK.

AGAIN, I APPRECIATE THE OPPORTUNITY TO PROVIDE THIS WRITTEN STATEMENT FOR THE COMMITTEE AND ADDRESS THE ISSUE OF HEALTH INSURANCE COVERAGE FOR ALL AMERICANS, PARTICULARLY THOSE IN RURAL AMERICA. I APPLAUD YOUR EFFORTS AND SINCERELY HOPE THE CONGRESS WILL SERIOUSLY CONSIDER THE NEEDS OF EVERYONE.

THANK YOU.

Written Testimony By Senator Paul Contillo

New Jersey State Senate District 38

On Behalf Of S 1265

Honorable Senators,

I wish to testify in writing on behalf of S1265, Fair Labor Standards Act of 1938 -- Minimum Benefits For All Workers Act of 1987, and ask for your support for this legislation.

An estimated 35 - 40 million Americans under the age of 65 live without health insurance coverage.

Two-thirds or more of uninsured Americans are employed workers and their families, who have no employer paid coverage and who cannot afford private health insurance.

One million American families have a family member who needs medical care, but for financial reasons, cannot afford it.

300,000 American families report a member denied medical treatment because of inability to pay.

In 1983, one million fewer people were covered by employer health plans than in 1982. Currently, some corporations have eliminated health benefits for retirees. Others are reported to be withdrawing all medical benefits for all employees.

As the dichotomy between rich and poor in America widens, the number of Americans who lack access to health care grows. More Americans may be finding work, but they are also finding that the jobs pay less, and offer fewer, if any benefits. In their attempt to reach self sufficiency, many Americans find themselves more and more vulnerable to the economic catastrophe that a serious illness can bring. Some claim this is progress. I see it as an American tragedy, and so, I firmly support this legislation.

As striking as these numbers may be, the can never communicate the dimensions of the pain and suffering that lies behind these facts and figures. Numbers tend to anesthetize. Individual cases of human suffering draw a much clearer picture of the need that exists throughout this country.

I will not take up your time with a recitation of case histories. As elected officials, we, and our staffs, hear these horror stories on a daily basis. During the course of these hearings, I am sure you will hear more. I would only ask that you listen to the plight of these millions of Americans. Do not discount their impact, or make excuses to defend the status quo. A problem exists in our country. If you do not feel that government should be the solution, at the least, act to mandate that others act responsibly, as this legislation requires.

I believe that the time has come for the federal government to focus on national health care and the American people seem to agree. In a recent poll six out of seven Americans said they believe everyone should receive the same high quality health care regardless of ability to pay. And in a survey regarding the Constitution, three out of four respondents would support an amendment guaranteeing every citizen's right to adequate health care, even if he or she could not afford to pay for it. Americans are fair and compassionate people and they recognize the inequities in our present health care system.

I also believe that this legislation is only a partial solution to the health care problems that exist in our country. There is no one prouder to be an American Citizen than I am. But I can take no pride in the fact that out of all the industrialized nations in the world, it is only the United States and South Africa which do not have a national health care program. National health insurance is a great journey away for America, but as with all journeys, it starts with one step. I see this legislation as a step, and I implore you to take it.

Thank you for your consideration.

NATS
NATIONAL ASSOCIATION OF TEMPORARY SERVICES
119 South Saint Asaph Street
Alexandria, Virginia 22314
703/549-6287

THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1987 [S.1265]

U.S. SENATE COMMITTEE ON
LABOR AND HUMAN RESOURCES

STATEMENT OF

THE NATIONAL ASSOCIATION OF TEMPORARY SERVICES

JULY 7, 1987

Statement prepared by:
Edward A. Lenz
Chairman, Legislative Committee

STATEMENT OF THE TEMPORARY SERVICES INDUSTRY REGARDING THE IMPACT OF THE MANDATORY HEALTH INSURANCE BILL (S.1265) ON TEMPORARY HELP COMPANIES*

S.1265 requires employers to provide health insurance benefits to their full-time and part-time employees who work at least 17 1/2 hours per week and their dependents. As currently drafted, the bill also appears to require coverage of temporary employees employed by temporary help service firms. Such a requirement is, for the following reasons, neither necessary nor appropriate.

- Temporary employment is short-term, sporadic and unpredictable, with temporaries often working for more than one temporary help firm. Identification of temporary employees to be covered and provision of conventional health coverage for such workers would not be economically feasible.
- The vast majority of temporary employees work as temporaries by choice and do not need coverage because most are already protected.
- The cost per temporary employee of providing a conventional health plan would be many times greater than for a full-time employee and totally disproportionate to the benefits actually provided.
- Thousands of temporary jobs would be lost (without a commensurate increase in full-time positions) because of the increased cost of temporary help services.

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*/ *This statement is submitted on behalf of the National Association of Temporary Services representing over 500 temporary help companies with over 4,700 offices in all 50 states.*

Accordingly, the temporary help industry respectfully requests that the Committee amend S.1265 to expressly exclude temporary employees from coverage.

The Temporary Help Industry

The temporary help industry, despite a few large companies such as Kelly Services, Manpower, and Olsten, consists largely of small independent business owners. Over 2,500 temporary help firms compete vigorously for both customers and employees.

Temporary help services help American businesses compete more effectively by providing essential support in virtually every job category, including office clerical, industrial, technical, professional, marketing support and health care. They provide business with a vital management tool to meet operating exigencies that cannot be met efficiently by full-time or part-time employees such as employee absences, variable production schedules, temporary skill shortages, seasonal workloads and special projects.

Temporary help firms provide competitive wages and benefits, make all payroll deductions, and pay social security and unemployment and workers compensation. Many also offer benefits similar to those offered to full-time workers such as paid holidays, vacations, bonuses, transportation allowances and free training. To a growing extent, health plans are being developed that are specifically tailored to the unique needs and work patterns of the temporary worker.

Unique Nature of Temporary Employment

Temporary help companies are employers with a work force that is unique in American industry. The fundamental premise of temporary work is that, unlike full-time and part-time workers who commit to a regular and ongoing schedule of employment, temporary employees have complete freedom to work when, where and how long they want. They may, and often do, work for more than one temporary help firm to maximize their freedom of choice. Because most work for very short periods of time for any one temporary help firm (in 1986, about half of all temporaries worked less than 12 days), annual employee turnover in the industry is an extraordinary 600% to 700%, compared to an average of 10% to 12% in other industries. No other industry operates on this basis.

Conventional Health Coverage is Not Economically Feasible

The legislation, by imposing conventional health coverage requirements on a non-traditional work force, would create an administrative, financial and actuarial nightmare for temporary help companies.

Because temporary employment is inherently short-term, sporadic and unpredictable, temporary help employers have no way of knowing at the outset or during the course of employment when or how long a temporary employee will work, or whether an individual will work for more than one temporary help firm during any given period of time. These facts and the extraordinary turnover of the temporary work force mean that the periods of employment of each of the 5 million people who work as temporaries during the course of a year (many of whom work on a sporadic basis) would have to be tracked. Moreover, detailed records would have to be established and maintained for over 2 million people who would be covered for very short periods of time.

The legislation would also impose an enormous financial cost on temporary help companies because premiums must be prepaid monthly and, because of the extremely high rate of turnover, thousands of temporaries would not work the full month for which the premium was paid. Any health plan that requires a temporary help company to bear costs the revenue generated by the productive hours of its employees will result in serious operating losses for that company. The extraordinarily rapid turnover in the temporary help industry will greatly magnify such losses as compared to industries with normal turnover rates.

Based on the average premium estimated by the bill's sponsor, the temporary help industry conservatively calculates that the total annual premium cost under the legislation would equal the aggregate 1986 pre-tax earnings of the entire industry.*

Compounding the costs described above is the actuarial nightmare that would be created by the ready access to temporary work and the absence of any obligation to commit to an ongoing employment relationship. Temporary help companies would sustain unusually adverse claims experience because people at the highest risk of needing medical services could elect to work briefly as temporaries solely to avail themselves of coverage. No employer could afford to pay for a health plan with such a high potential for adverse selection.

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*/ *This cost estimate is based on providing health coverage to an estimated 2.4 million temporary employees who would meet the eligibility requirements each year (i.e., those who would work at least 17-1/2 hours per week over a period of 30 days or more).*

Temporary Employees Need Not Be Covered Under A Mandatory Health Insurance Law Because They Are Already Protected

While about 5 million people currently choose to work as a temporary at some time during the course of a year, only 800,000 work on any given day -- less than 1% of the work force.

As a group, temporary employees have good skills, are well educated (most have at least some college education) and work as temporaries out of choice because it is uniquely suited to their lifestyles and economic needs. Temporary work affords freedom, flexibility and immediate employment at competitive pay rates. The majority are married women, retirees who want to supplement their income, students and teachers who work during school breaks and holidays, and technical and professional workers. The vast majority of these individuals already have health insurance coverage.

Temporary work also provides a "bridge" to full-time employment for people between full-time jobs, those looking for first time job experience, and individuals who have been out of the work force and need to refresh their skills. Many of these workers have coverage, but even those who do not are for the most part at relatively low risk because they generally work for short periods of time before finding full-time positions, most of which do provide coverage. In addition, for those who have quit their jobs or been terminated, the continuing coverage provisions of the 1985 Consolidated Omnibus Reconciliation Act (COBRA) affords most workers the opportunity to buy coverage at favorable group rates for up to eighteen months.

In total, industry surveys show that of the approximately 800,000 people who work as temporaries at any given time, about 55% (440,000) already have spousal, family or their own health coverage. In addition, about 35% (about 280,000) are in between full-time jobs and are at relatively low risk for the reasons previously stated. Hence, only about 10% (80,000) of all temporaries working at any given time are unprotected.

Of the temporaries who are currently unprotected, we estimate that about half have access to coverage under various plans offered by temporary help companies themselves. To a growing extent, temporary help companies are implementing health plans designed specifically for the temporary work force. Some provide coverage to temporaries that satisfy certain minimum service requirements each month. Others arrange for employees to buy coverage at rates comparable to the most favorable group rates. These plans are designed to provide a cost-effective benefit consistent with the unique needs and work patterns of temporary employees. The evidence to date suggests that these plans are attracting temporary employees who are not already covered by insurance and who feel they need it.

In sum, therefore, the number of temporaries who may be at risk (about 40,000) is very small. Moreover, many of these individuals would not work long enough to be eligible for coverage under the legislation. It is clear, therefore, that temporaries do not contribute in any significant way to the problem which this bill addresses.

Conclusion

The temporary help industry has an excellent record of meeting the unique needs of its employees. Temporaries enjoy the advantage of being able to work when, where and for as long as they want. For the relatively few who want or need health coverage, the industry is responding with benefit plans that make economic sense for both the employer and the employee. By imposing conventional coverage requirements on the unique and non-traditional temporary work force, the legislation would drastically increase the cost of temporary help services and reduce employment opportunities for thousands of people, most of whom do not need protection. For these reasons, we respectfully urge the Committee to amend S.1265 to expressly exclude the temporary employees employed by America's temporary help companies.

NRC

July 8, 1987

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

The undersigned organizations of the National Rehabilitation Caucus (NRC), are seriously concerned that the "Minimum Health Benefits for All Workers Act of 1987", as introduced, unwisely limits access to rehabilitation services to the detriment of American workers. On June 3, 1987, many NRC members met with senior health policy analyst, David Nexon, to discuss S. 1265, During that meeting, Mr. Nexon invited the NRC to submit language that would amend S. 1265 to include coverage for non-hospital rehabilitation services. We understand that the bill, as introduced, includes both inpatient and outpatient hospital rehabilitation services.

We urge you to give careful consideration to our recommendations regarding mimumum rehabilitation coverage. Per Mr. Nexon's request, our comments emphasize the prevalence of existing coverage for such services, as well as their cost-effectiveness and overall importance to quality health care. Kindly include these comments in the record for the hearings concerning S. 1265, held on June 24, 1987.

NRC member organizations represent a broad spectrum of rehabilitation service providers, professionals and related interests. While the NRC recognizes that there is considerable pressure to limit benefits under this proposal, we also believe that access to rehabilitation services in acute, home and community-based settings is critical to a minimum health benefit plan for American workers.

Rehabilitation services promote the restoration of functional abilities of individuals with physical, communicative, cognitive, and sensori-perceptual impairment. Rehabilitation includes a broad range services, including physical therapy, speech-language pathology, occupational therapy, audiology, rehabilitation nursing, assistive device technology, homemaker-home health aides, and physician services. Rehabilitation occurs in a variety of settings, such as hospitals (freestanding and distinct rehabilitation units), rehabilitation agencies, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and private offices and homes. The extent to which medically necessary services are covered often involves limitations on duration and frequency of service, and caps on expenditures.

Quality health care includes a broad spectrum of hospital, home and community-based rehabilitation services. Rehabilitation is tailored to the unique needs of the patient. Consequently, access to a range of services in a range of settings maximizes patients' opportunities to receive timely and appropriate care and maximizes individual function, independence, and ideally, return to work.

Limiting rehabilitation coverage under S. 1265 to hospital settings seriously jeopardizes employee access to high quality service alternatives in the home and community. This strategy fails to consider the trend towards shorter hospital stays, which has shifted a substantial level of intensive rehabilitation care to settings other than hospitals. Furthermore, for workers and their dependents with serious illness, injuries, and disabilities, limits on access to care frequently translate into less than optimum recovery.

Early access to rehabilitation services frequently prevents the development of secondary problems, either physical, mental or behavioral, which can have an enduring and detrimental influence on an employee's recovery process. If rehabilitation is appropriately timed for critical periods in the recovery process, immediate and long-term treatment effects are going to be greater than if the same rehabilitation services are provided after those critical periods.

For these reasons, we believe that individuals covered under S. 1265 deserve the opportunity to receive services in the setting most appropriate to their personal and health needs. At a minimum, therefore, rehabilitation services available in hospitals also should be covered in home and community settings.

In terms of cost-effectiveness, rehabilitation ranks favorably as an alternative to extended acute care. Research shows that the average costs for rehabilitation are two-thirds that of acute care. For example, early rehabilitation saves an average of $6,404, for each surviving stroke patient fortunate enough to receive it. In fact, cost studies of stroke rehabilitation show considerable return on the investment in services. A person who is not rehabilitated costs $92,736 in 1980 dollars more to support than a rehabilitated patient living at home. The average cost of rehabilitating an individual who has had a stroke is $8,000 to $11,500 in 1980 dollars. This results in average savings of $81,250 to $84,740, again in 1980 dollars.

Notably, a recently completed survey by the Health Insurance Association of America concluded that for every dollar spent on rehabilitation, $11.00 is saved in other benefits that would have been paid to the affected individuals.

Other studies have shown similar results:

* A 1981 Insurance Company of North America study concluded that in long-term disability cases, for every dollar spent on rehabilitation, $17.00 is saved in other benefits that would have been paid to the beneficiary.

* In 1981, Natisco Rehabilitation Management, Inc., a case management company, estimated that for every dollar spent on rehabilitation, $12.68 was saved in claim costs.

* Several studies on spinal cord injuries concluded that for every dollar spent on rehabilitation, $3.00 to $6.00 is saved.

In order to take full advantage of rehabilitation's cost-effectiveness coverage for these services must extend to a variety of settings. The NRC recommends, therefore, that S. 1265 be amended to reflect that rehabilitation in hospital, home and community settings is considered an integral part of the minimum employee health benefit.

Coverage for rehabilitation services is widespread. Public and private health insurers customarily include some level of coverage for rehabilitation services in the benefits they offer. Coverage for rehabilitation services is delineated in terms of type of service, site of service delivery, and scope of service, and describes which services are covered, where services are covered, and how services are provided.

A substantial share of employee health plans include coverage for rehabilitation services. For many employers, the impetus for including this coverage is based on the recognition that the relative costs of rehabilitation services are preferrable to the high costs associated with long-term worker disability. In 1985-86, the Institute for Rehabilitation and Disability Management, a joint venture between the Washington Business Group on Health and the National Rehabilitation Hospital, conducted a national survey of 400 major employers. Some of the significant findings include the following:

* Sixty-five percent of the surveyed companies reimburse for rehabilitation services in community hospitals, while sixty-one percent reimburse for rehabilitation services in rehabilitation specialty hospitals.

* Seventy-two percent of the responding companies reimburse for outpatient rehabilitation services.

* Eighty-one percent reimburse for inpatient and outpatient physical therapy.

* Fifty-three percent of the responding companies reimburse for home-based rehabilitation services.

Thus, a minimum benefits package that would exclude rehabilitation services provided in settings other than hospitals would undercut benefits currently provided by most major employers. Rehabilitation services have been added to employer-paid health benefit plans at little or no cost. In Maine, for example, an insurer added speech-language pathology services to a health plan with no increase in cost. Similar coverage by other insurers has resulted in additional premium costs ranging from $0.12 to $0.48 per employee per month.

States have also realized the value of worker access to rehabilitation services. Workers' compensation programs, present in all 50 states and the District of Columbia, routinely provide for some level of rehabilitation care. Rehabilitation service provisions range from minimum assistance, such as in Indiana and South Carolina, to full coverage of the costs of physical rehabilitation, as is the case in Oregon, Ohio, Texas, Kentucky, Massachusetts, Alabama and Alaska. In West Virginia, medical services and devices are authorized for physical rehabilitation. Additionally, provisions for compulsory rehabilitation, often furnished at the employers' expense, are contained in the workers' compensation laws of Connecticut, California, Delaware, Florida, Minnesota, Nebraska, Nevada and New Hampshire.

In addition to the broad coverage extended to rehabilitation services in federal health programs, such as Medicare and Medicaid, there is a precedent for federally-mandated minimum health coverage that includes rehabilitation. Under the Federal Health Maintenance Organization (HMO) Act of 1973, guidelines specifically require that short-term rehabilitation services be available to enrollees. Unfortunately, HMO interpretation of this requirement remains a problem. Additionally, the Group Health Association of America reports that 99% of HMO plans offer physical therapy services, 97% offer home health benefits, 91% offer benefits for communicative disorders that are delivered by speech-language pathologists, and 80% offer occupational therapy benefits.

NRC Recommendations

Based on this evidence and the belief that a meaningful mandated minimum health benefit must include access to a range of rehabilitation services in acute, home and community settings, the NRC urges you to amend S. 1265 by adding to Section 312(a)(2) "and rehabilitation" after the word "physician". Report language accompanying the bill must reflect that rehabilitation includes services, such as physical therapy, occupational therapy, speech-language pathology, audiology, rehabilitation nursing, homemaker-home health aide, and assistive devices in home and community-based settings.

Incorporation of coverage for these rehabilitation services in your mandated minimum health benefits legislation will effectively provide access to such services for most of the workers you intend to assist. In the absence of coverage for these services, many workers will simply forego needed rehabilitation care, thereby jeopardizing their health and risking more serious and costly health problems in the future. Ultimately, passage of a mandated minimum health plan which adequately provides for rehabilitation services beyond the hospital setting is in the best interest of employers and will appropriately address the health needs of American workers and their families.

Thank you for your consideration of our recommendations presented here and summarized on the enclosed sheet.

Sincerely,

Steven C. White

Steven C. White, Ph.D.
Chairperson

On behalf of:

American Academy of Physical Medicine and Rehabilitation
American Congress of Rehabilitation Medicine
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
National Association for Home Care
National Association of Rehabilitation Agencies
National Association of Rehabilitation Facilities
National Easter Seal Society

cc: The Honorable Henry Waxman
David Nexon
Courtney Pastorfield

NATIONAL REHABILITATION CAUCUS RECOMMENDATIONS

Home and Community-based Rehabilitation Benefits
As Minimum Health Benefits For All Workers (S. 1265)

Proposed Amendment:

Add to Section 312(a)(2) "and rehabilitation" after the word "physician".

Report Language Recommendation:

Include detailed report language which assures that the definition of rehabilitation includes physical therapy, occupational therapy, speech-language pathology, audiology, rehabilitation nursing, homemaker-home health aide, and assistive devices provided by qualified professionals in home and community settings, such as rehabilitation agencies, comprehensive outpatient rehabilitation facilities, skilled nursing facilities, home health agencies, private offices and homes.

The NRC recommends that these services be provided as needed to mitigate or eliminate functional limitations, with provision for review of medical necessity for further treatment or related services through peer review arrangements.

Copayments and Deductibles:

All copayments and deductible amounts and percentages should be consistent with those required for other benefits in the bill.

For further information contact: Steven C. White, Ph.D.,
(301) 897-5700

July 8, 1987

STATEMENT
ON BEHALF OF THE
NATIONAL RETAIL MERCHANTS ASSOCIATION
BEFORE THE
COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
CONCERNING S. 1265
MINIMUM HEALTH BENEFITS
FOR ALL WORKERS ACT OF 1987

This statement is submitted by the National Retail Merchants Association ("NRMA"), in response to the pending legislation entitled the Minimum Health Benefits For All Workers Act of 1987 (S. 1265). NRMA is the largest national trade association representing the general merchandise retail industry. Our 3,700 members operate more than 40,000 leading chain, department, specialty and independent stores across the country. The bulk of NRMA's membership, however, consists of small, locally-owned retail establishments throughout the nation. Collectively, NRMA members' current annual sales exceed $150 billion and they employ more than 3 million workers.

While we recognize that this legislation is well-intentioned, it is the view of NRMA's membership that S. 1265 would mandate a costly and inflexible employee benefit program which would be unworkable for many of NRMA's members - particularly its smaller members - and would impose unnecessary constraints on the proper management of their businesses.

Many NRMA members already provide health insurance coverage for their employees because they recognize such benefits are helpful or necessary to retain and attract talented employees. However, because of the highly competitive nature of the retail industry, and the very narrow profit margins under which our members operate, voluntary programs which allow individual employers to design systems which will work best for their businesses and their employees are far preferable to a mandatory, inflexible program. Therefore, we oppose legislation compelling employers to provide specific benefits or coverage. This proposed legislation disregards the need for flexible, creative employee benefits designed to satisfy business circumstances and individual employee considerations. Moreover, if enacted, this legislation may well result in reductions of other voluntary employer-paid benefits, such as vacation pay, life insurance and retirement benefits. Furthermore, this proposed legislation represents only one of a series of pending Congressional proposals which seek to impose government-mandated benefit plans on private employers. NRMA members firmly believe that in a free economy, employers and employees, not Congress, are best able to fashion benefits structures most suited to their needs.

Beyond our opposition to the principle of mandating costly employee benefits, NRMA objects to many of the specific provisions of S. 1265. Some of the most troublesome are the following:

1. We understand that the cost of this proposed mandatory insurance program would be in the range of $650 per

year for individual employees and $1,600 per year for family coverage. Many small retail establishments simply could not afford such costly employee benefits. The imposition of this costly benefit on many small retail establishments (most of which do not provide health insurance coverage because they cannot afford to) may result in store closings, staff reductions, and discourage new hiring. To reduce the risk of these adverse consequences, we urge that employers with less than 50 employees be exempted.

2. S. 1265 would require that the employer-provided health insurance plans cover employees' spouses and their children as well as the individual employees themselves. This is tantamount to mandatory national health insurance coverage funded by employers. If the underlying goal of this proposed legislation is national health insurance coverage, then efforts should be made to provide such insurance through a tax structure, not by placing the burden of paying for it entirely upon employers.

3. S. 1265 would permit an employee to opt out of "double coverage" for a spouse or child. However, there is no compelling reason why an employee would ever do so. In fact, employees and their families may be able to obtain 100% coverage (in contrast to the Act's 80% limitation) when both spouses are covered by their separate employer's plan, or a

child who is covered by his employer's plan is also covered by his parent's employer's plan. In addition, S. 1265 provides no mechanism to police against double coverage. For the reasons previously discussed, we urge that the family coverage requirement be eliminated or, at the very least, this double coverage problem be dealt with more equitably.

4. S. 1265 would limit the premium that can be charged to the employee to 20% of the actuarial rate of the plan and prohibits charging premiums to employees earning less than $4.19 per hour in 1988. Due to the high cost of this coverage and the inherent danger of this program cutting into other employer-provided benefits, we urge that the employee contribution limit for individual employee coverage be raised to at least 50% with no exclusion from contributions for lower-paid employees, and if family coverage is mandated, the employee contribution limit for such coverage be raised to at least 70%.

5. S. 1265 would require employers to provide health insurance to all employees who work over 17-1/2 hours per week. This is not workable in two respects. First, the 17-1/2 hour per week standard is too low. It covers virtually all part-time employees. To require an employer to provide insurance coverage which may cost in the range of $1,600 per year to an employee who may only be earning $3,048.50 per

year (e.g., 17-1/2 hours at $3.35 per hour for 52 weeks) is unreasonable. We urge that the minimum hours per week standard be raised to 35 hours per week. Second, the Act does not prescribe any criterion by which to apply the minimum hours per week requirement. We would suggest that an employee be covered only if he/she is regularly scheduled to work the minimum hours per week (i.e., excluding overtime hours).

6. S. 1265 does not even provide for a minimum period of employment to become eligible for the mandatory insurance coverage. A minimum tenure, such as one year, should be established before an employee is entitled to the mandatory coverage prescribed in S. 1265.

7. S. 1265 would compel employers to offer insurance covering inpatient and outpatient hospital care, inpatient and outpatient physician services, diagnostic and screening tests, prenatal and well-baby care, and all preexisting conditions. This provision effectively precludes employers from offering "cafeteria" health benefits programs, which may be more beneficial to employees than the mandated overall coverage.

8. S. 1265 would establish health insurance regions within which the Federal government will certify two to five regional insurers. After the effective date of the

Act, every employer that does not provide health insurance to its employees and every employer with fewer than 25 employees that changes its insurer will be required to provide coverage under the Act through one of these federally certified regional insurers. Although a regional plan may lead to lower costs, our members believe that such a requirement is overly restrictive and anti-competitive. Non-certified insurers may very well be able to provide the mandated benefits with better service or at a cheaper cost to employers than certified regional insurers. We would suggest that the option of whom to engage as an insurer be left to the individual employer so long as the mandated benefits are provided.

9. By imposing certain employee benefits upon employers with union-represented workforces, S. 1265 would infringe upon the collective bargaining process provided for in the National Labor Relations Act.

Conclusion

NRMA is sympathetic to the laudable goals of S. 1265. However, we firmly believe that mandatory health insurance coverage paid for primarily by employers is the wrong way to achieve these goals. We urge the Committee to recognize the fundamental differences which exist from industry to industry and from employer to employer, and to reject any proposed legislation which attempts to mandate a single, inflexible health insurance program to be provided by all employers. We believe that the competitive marketplace should dictate what benefits are provided by which employers to which employees. The system should continue to reflect each company's individual philosophy, operations and needs.

This proposed legislation, along with at least two other presently pending bills (the Parental and Medical Leave Act and an amendment to the Fair Labor Standards Act to increase the minimum wage), seeks to burden employers with the costs of dealing with societal problems. Each of these bills, however, would have an adverse impact on employers and their ability to employ more people. We strongly recommend that the Committee not endorse legislation such as S. 1265 which would require a single, minimum health insurance coverage program for all employers.

STATEMENT
OF THE
SELF-INSURANCE INSTITUTE OF AMERICA, INC.
ON
S. 1265
THE MINIMUM HEALTH BENEFITS
FOR ALL WORKERS ACT OF 1987

SUBMITTED TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

This statement is submitted on behalf of the Self-Insurance Institute of America, Inc. ("SIIA"), a national association of over 600 members including employers, third-party administrators, insurance companies, reinsurance companies and other interested parties representing over 30 million participants. Dedicated to the advancement of self-insurance, SIIA is the only association in the U.S. which represents firms, professionals and organizations which participate in the broad spectrum of self-insurance.

SIIA appreciates the opportunity to express its views in connection with the Committee's consideration of "The Minimum Health Benefits For All Workers Act of 1987" (S. 1265).

Under S. 1265, all employers would be required to provide a minimum health benefits package to employees (working 17-1/2 hours per week or more) and their dependents. Employers would be required to pay 80% of premium costs for most workers and the entire cost for low wage workers (those earning less than $4.19 per hour). The benefit package must include medically necessary hospital care, physician care, diagnostic tests, pre-natal care, and well-baby care.

Historically, Congress has not enacted legislation mandating specific benefits in private health plans. Instead, Congress has favored policies which have promoted the growth and success of a private, voluntary approach to health care benefits for workers. SIIA believes that these policies have served the needs of American workers and their families well and should not be modified at this time.

The current federal legal framework has been vital to the success of the present private-sector approach in meeting consumer health needs. This has been accomplished through broad tax incentives for employers to provide group health care benefit plans for their employees -- without federal "strings" dictating the terms of their plans. Employers currently spend more than $100 billion each year on health care for employees and their families and provide about 85 percent of total private health care coverage to 132 million people under age 65 through voluntary employer-sponsored plans. Employers also pay a large share of the cost of public health programs through taxes and contributions. This private sector system has effectively funded the most advanced health care system in the world.

Increasingly, there has been a tendency to look to the voluntary private health care system as the vehicle to provide solutions to certain health care problems -- such as the problem of the uninsured. During a period of federal budget deficits and spending reductions, it has been good "politics" to seek solutions to social problems through the private sector instead of through new federal spending programs.

No one would disagree that adequate health care coverage for all who need it is an important societal goal. Indeed, we agree that it is unacceptable that some Americans are denied access to health care because they are unable to pay for it or because they are not covered by health insurance. However, it is important for all elements of society -- not just the employer community --

to commit the resources needed to achieve that goal. S. 1265 places the total burden for this societal problem on the employer community -- an approach which surely will weaken this proven successful system. At a time when a consensus for national health insurance has not developed, the mandatory approach appears to be a "back door" attempt to create a legal framework leading to a broader national health program. Moreover, some observers have already noted that a minimum health package such as that proposed would be a focal point down the road for myriad federally mandated benefit "add-ons".

Our economy has created 12.4 million jobs in the last 4 years -- most of them small businesses, which are particularly at risk from increased labor costs. For small employers operating at a low profit, or start-up firms with no profit margin, the new federal program would be particularly burdensome. National surveys indicate that concern over government mandated health benefits has replaced concerns about liability insurance as the number one worry for small business. Many small firms faced with the federal mandate would be forced either to lower wages, reduce their workforce, or discontinue operations. These actions would result in less rather than more access to health care coverage and would result in reduced employement. Additionally, the higher health care costs would not be limited to small business but would impact on medium-size and larger businesses who purchase services from smaller firms. Thus, the proposed mandatory approach will create not only a small business problem, but a problem which impacts on all business. More specifically, the mandatory approach will contribute to higher inflation and will tend to make U.S. firms less competitive with foreign firms.

No single solution is likely to solve the problem of the uninsured in the United States. In the search for solutions to the problem of expanded health care coverage, rather than target business -- and especially small business -- it may be useful to recognize certain realities:

(a) additional financial resources, in the form of direct government funding, tax expenditures, and private sector funding will be necessary.

(b) to help assure access to adequate health care for those in the labor force, existing employer incentives to provide health insurance to employees and their dependents should not be jeopardized; there must be additional incentives for individuals and small employers to provide benefits.

(c) mandating that businesses offer and/or pay for expanded coverage undermines the voluntary, flexible, private-sector employee benefits system. Shifting the burden for expanded health coverage to employers is not a cost free way of dealing with expanded coverage. Such a mandate leads employers to reduce overall health care coverage, abandon their health plans or decide against starting health plans.

SPBA SOCIETY OF PROFESSIONAL BENEFIT ADMINISTRATORS
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Testimony to the United States Senate
Committee on Labor & Human Resources
on S 2165
The Minimum Health Benefits for All Workers Act of 1987
from the Society of Professional Benefit Administrators (SPBA)
presented by Frederick D. Hunt, Jr., President
accompanied by Anne C. Lennan
June 24, 1987

The Society of Professional Benefit Administrators (SPBA), founded in 1975, is the national association of independent third party contract benefit administration firms. It is estimated that one third (1/3) of all U.S. workers are covered by employee benefit plans administered by such firms.

SPBA members operate much like independent CPA or law firms... providing continuing professional out-of-house claims and benefit plan administration for client employers and benefit plans. Most of the plans employ at least some degree of self-funding. Client plans include those sponsored by corporations of all sizes, associations, and union/management jointly-administered Taft Hartley multi-employer plans.

SPBA membership has grown almost 700% in the past 6 years... with a current roster of almost 400 member firms. Similarly, SPBA members have seen the market for their services also expand rapidly...in large part because of the leading role of SPBA members have played in successful health cost containment efforts and cost-efficient administration techniques for pension and health benefit plans.

Mr. Chairman, we genuinely appreciate the opportunity to ~~appear~~ submit written testimony today. Our testimony is based on practical hands-on experience from our member firms who know employee benefits from the perspective of every size and format of employment. We also come with an independent arms-length view. We are here to be constructive and candid. We have no axe to grind. We have 11 major suggestions and observations to assist in the goals of this bill. Let me begin.

1. TAFT-HARTLEY PLANS KILLED? - The bill should be clarified or strengthened as it applies to about 1/3 of the workforce who have little or no employer/employee relationship. The largest proportion of such workers are unionized in such trades as

W. Ashby Harden, Chairman of the Board — Corporate Employee Benefit Administrators, Oakland, CA
William C. Earhart, Vice Chairman — William C. Earhart Co., Portland, OR
Richard A. Roop, Bd. Secretary/Treasurer — Business Administrators & Consultants, Reynoldsburg, OH
John Timmer, Immed. Past Chairman — Employee Services, Inc., Sioux Falls, SD
T.J. Chapman — Boon-Chapman, Ltd., Austin, TX
Ted B. Hale, Jr. — Self Retention Systems, Palmyra, NJ
Edward Hightower — Executive & Employee Benefit Plans, Inc., Atlanta, GA
Marlene Sharp — Palmer & Cay/Carswell Benefit Services, Inc., Savannah, GA
Frederick D. Hunt, Jr. — President

Past Chairman's Council: Robert E. Kelly • Steven L. Sherman • Charles B. Jackson • Glen K. Slaughter • W. Richard Perkins • James M. Dawson • Robert B. Swanke

plumbers, electricians, carpenters, etc. They work only a few hours, days or weeks per project (employer) and might even work on more than one project (employer) on any one given day. In such cases, the person is not "hired" in the sense that most of us know it. In fact, the employer often never knows who he employed or for how long until he gets a bill at the end of the month from the collectively-bargained employee benefit plan which says the employer owes X dollars for Y hours worked by participants in the plan.

In the majority of cases, the worker probably never stays with one job long enough to qualify for coverage under the provisions of this bill. That is why the Taft-Hartley Act of 1946 was passed, to allow employers and unions to work together to provide coverage to such workers who would not otherwise ever be able to earn coverage. The Taft-Hartley Act has worked extremely effectively. Since most employers who participate in such Taft-Hartley plans have less than 25 permanent employees (and they would have no way to consistently count how many "employees" they might have at any one hour, day, or year if the rotating union workers were to be counted), most employers who now or in the future would participate in such Taft-Hartley plans would fall under the requirements of Section 301(b)(2)(A) (i+ii)...requiring them to either start out or shift into regional insurer plans. Without those new and continuing employers to participate in Taft-Hartley plans, those plans will dwindle and die (possibly having financial problems at the end, which could hurt the last participants). Thus, the net effect of what I believe was an oversight, would be to essentially phase out the excellent system devised by the Taft-Hartley Act for multi-employer plans...prevent many workers who currently get employer-paid and continuing coverage from this source, and remove a major advantage of workers belonging to unions.

We would strongly recommend that a paragraph iii be added to Title III Part A, Section 301(b)(2)(A) which states that "Employers who participate in multi-employer plans for their workers under the authority of the Taft-Hartley Act are exempt from paragraph i and ii of Section 301 of this title".

2. ASSOCIATION (MEWA) PLANS ENCOURAGED - Similarly, we suggest that Section 324(b)(1) be clarified so that plans sponsored by trade associations, known as Multiple Employer Welfare Arrangements (MEWAs) in the lingo of ERISA, be specifically named (along with "small service bureaus and chambers of commerce" which appear in parenthesis in Section 324(b)(1)). We would also recommend that such groups which have proved themselves to be cost-effective in expanding coverage for workers not

simply be subject to the whims of regional insurers. Thus, we would recommend the first sentence of Section 324(b)(1) should read: "The Secretary shall DIRECT regional insurers to enter into appropriate arrangements with INTERESTED entities representing groups of small businesses (such as small business service bureaus, chambers of commerce, TRADE ASSOCIATIONS, and MULTIPLE EMPLOYER WELFARE ARRANGEMENTS) for the provision of FUNDING OPTIONS and administrative services with respect to small businesses enrolled in plans offered by insurer".

3. FINANCIAL STABILITY OF REGIONAL INSURERS - There is tremendous concern that today's diverse and well-spread health coverage risk would be narrowed by this legislation into a mere 40 "regional insurers" (based on up to 8 regions and 5 regional insurers per region). With the tremendous financial risks we face now and in the future, and considering the instability which many insurance companies have been facing...it is scary to think that the options for spreading and funding the risk would be so dramatically narrowed. We fear that the tremendous increase in risk, the narrowed spread of that risk, and restricted flexibility in pricing on the part of regional insurers is a recipe for disaster (and Federal subsidies) just a few years down the road.

We would definitely warn that financial stability and competitiveness demand that they be much more optional. The concept as now written in the bill dismisses the great strides that have been made in expanding coverage and cost-effectiveness via self-funding (even for very small employers) and various innovative methods of plan administration and plan design. At least half of all employee benefit plans now use self-funding and/or cost-effective new ways to provide benefits and tailor them to the needs of workers. To return to just a handful of huge fully-insured plans is tantamount to fighting the energy conservation battle by demanding that most people drive gas guzzlers. The current system works well and seems to improve each year (and the option of regional insurers might well be such an option and improvement). As Burt Lance once told this Congress, "If it ain't broke, don't fix it". We would urge you to amend the legislation to make the regional insurers an optional method of providing the required coverage...not a strong-arm tactic which forces most employers into that method.

4. PRE-EXISTING CONDITIONS AND EXCLUSIONS - You will find significant concern expressed about Section 313(c), prohibition of pre-existing conditions and exclusions. While I know that the intent of the bill is that the risk will all even out once every

employer is covered, there is great fear that such blanket prohibitions of controlling risk...without off-setting financial considerations to protect the stability of the insurer and other healthier workers...there could be extremely serious funding problems in a very short time. Presumably, Uncle Sam would be called upon to bail out such problems.

5. ASSURE MEDICAL COST SAVINGS - We would strongly encourage you to strengthen one portion of the bill to better assure its goal. Though it does not appear in the actual language of the bill, one of the major advantages being claimed for this legislation is that as soon as everyone is covered, medical prices will go down because doctors, hospitals, and other medical providers will no longer have to charge higher prices to covered patients in order to subsidize their care for non-covered patients. To assure that this bill achieves its intended cost-savings, a new section should be added to the bill which forces all medical charges to be lowered 10% on the effective date of the law. To avoid hanky-panky between now and then, wording should be added that the medical charges will be based on those charged on May 19, 1987, (to be consistent with Section 313 of the bill)...and that the medical charges cannot be raised more than the CPI for all Urban Consumers for each year from 1987 on (language consistent with that relating to the CPI limits on rises in Section 314(2)(B)(ii)).

6. PREEMPTION CLARIFICATION - Section 202 of the bill, relating to preemption of state laws, which would amend ERISA, probably needs some clarification. Unfortunately, the issue of preemption has been very widely confused and misinterpreted over the past 13 years. This bill would provide a good opportunity to clarify that. We suggest the following wording to start Section 202(a)(2): "ANY AND ALL HEALTH BENEFIT PLANS OBEYING TITLE III WOULD PREEMPT any provision of the law of any State to the extent that such provision regulates, or otherwise provides any requirement relating to, contracts or policies of HEALTH COVERAGE OR insurance issued.....". We fear that the current reverse negative wording used at the start of Section 202(a)(2) might inadvertently perpetuate the unfortunate friction and confusion that have frustrated employee benefit plans and regulators since the passage of ERISA.

7. ADMINISTRATION OF LIMITS - The limits on premiums, deductibles and co-payments, while well-intentioned, will probably be extremely complex and expensive to administer, especially in employment formats in which there is not a direct employer/employee relationship (such as the unionized workers mentioned earlier in this testimony). We would urge you to keep this process as streamlined and cost-effective as practical.

8. SECTION 402 IS GREAT - We strongly endorse Section 402 of the bill to require careful study before adding additional benefits to those mandated. In Section 402(b), we would suggest that those specifically designated to review proposed new benefits, not only reflect academic and research perspectives...but also non-profit unbiased entities such as the Society of Professional Benefit Administrators who can bring hands-on expertise to the considerations. The Society of Professional Benefit Administrators is unique in that an estimated 1/3 of all U.S. workers are covered by plans administered by member firms. Not only does that make it one of the single largest voices, but SPBA also reflects every size and format of employment and plan (union, non-union, big business, small firms, fully-insured, self-funded, etc.). Best of all, the Society of Professional Benefit Administrators is unique in the employee benefits arena because it has an independent arms-length relationship with the plans, sponsors, and funding methods. We have no axe to grind. With this testimony, we volunteer to serve at any time in the duties prescribed in Section 402...and we urge that such practical hands-on expertise and perspective be written into the wording of the law as part of the considerations required in Section 402.

9. OTHER LAW COORDINATION - Related to Section 402, we would urge that the wording of the bill and also the regulations and oversight of the Secretary review the effect (often duplicative or contradictory) of current mandated benefits and tax laws affecting employee health plans...such as COBRA and DEFRA.

10. FEDERAL EMPLOYEES (ALL KINDS) COVERED - The bill seems to be mute on the question of whether the law would apply equally to Federal employees and/or if there are differences between civil service workers, political appointees, Congressional staff, military, independent agencies, and quasi-governmental organizations, such as the Smithsonian, AMTRAK, Red Cross, etc. We would urge that because such a tremendous

proportion of our population (reportedly up to 20%) are employed by such Federal government entities...the intent of this legislation would be thwarted if all Federal government entities were not equally subject to the law. The compliance/incentive for such Federal offices would be a 10% reduction in their appropriation.

11. WHAT IS LEFT - Finally, related to our suggestion that all Federal employers be included in the law, we must warn against overly-optimistic assumptions that this law will eliminate the problem of uncompensated health care. We have all heard the number "37 million" thrown around as the estimate of those without health "insurance" coverage. That is somewhat misleading. It includes millions of people who have no need for health "insurance" because they have health coverage provided through non-insurance mechanisms. The millions upon millions of Americans who have free access to military and government medical services is a good example. There are also many hospitals which provide the medical care directly themselves to their workers and dependents. Also many of our elderly have been led to believe that Medicare is their comprehensive medical coverage. We are working now with the office of Secretary Bowen to help educate the American public on this latter point. In any case, I have heard that the "37 million" of truly uncovered should be closer to 20 million.

Of that 20 million to whom this bill is truly aimed, a large proportion will continue to be uncovered. About 90% of all U.S. workers now get employer health coverage or care. Thus, there is only 10% of the workforce (mainly small employers) who are yet to have coverage. However, there are millions of people who have no employer relationship and who would be untouched by this bill. Thus, at the risk of sounding like party-poopers, we urge you not to get carried away with a euphoria that this legislation (or any legislation) will totally erase this problem.

Mr. Chairman, members of the committee, we thank you for the opportunity to testify, and we look forward to working with the Congress and Secretary of Health & Human Services to solve problems in the most practical and cost-effective manner possible.

Society of Professional Benefit Administrators
SPBA
MEMBER

UFCW

Arnold Mayer
International Vice President
Director, Public Affairs Department

July 1, 1987

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The United Food and Commercial Workers International Union supports S. 1265 - the "Minimum Health Benefits For All Workers Act of 1987." The goal of medical protection for all workers is one which we have consistently supported. Legislation to secure health coverage for the uninsured is badly needed.

However, we do have one major reservation. The UFCW strongly opposes premium co-payments for employee coverage. Such co-payments constitute an economic burden for workers. Although the bill exempts those individuals earning less than 125% of the current minimum wage from the co-payment provisions, it does not go far enough. Minimum health benefits for the employee, himself or herself, should be an employer responsibility. Full employer paid premiums would guarantee that all workers would receive the health care coverage, they so desperately need.

The UFCW, therefore, strongly urges that the Committee amend S. 1265 to provide for Full employer payment for the health insurance of the employee, but not necessarily for his or her dependents. We look forward to working with you on this issue.

Sincerely yours,

Arnold M. Mayer

Arnold Mayer
International Vice President
Director, Public Affairs
Department

AM:KT:sk

William H. Wynn
International
President

Jerry Menapace
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Secretary-Treasurer

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Yaffe
& COMPANY

Rian M. Yaffe
President

Testimony before the Senate Labor and Human Resources Committee
"Minimum Health Benefits for All Workers Act of 1987" - S.1265

June 24, 1987

Mr. Chairman:

Senator Edward Kennedy has wanted to provide national health insurance for many years. Since the government cannot afford to pay for it, his bill - "Minimum Health Benefits for All Workers Act of 1987" calls for employers to bear the cost.

Although philosophically I am against mandated benefits, the real problem with this bill rests with two particularly objectionable provisions.

First, requiring employers to pay 80% of the cost is to too much. But worse is the provision that employees cannot waive coverage even if they are covered somewhere else, such as by a spouse's plan.

Employees should be able to choose the coverage which best meets their needs. Why should coverage by the employer be mandatory even if the employee has proof of coverage elsewhere? This bill could have been written - and would have provided "Miniumum Health Benefits for All Workers" - without this provision. I believe the reason for it is readily apparent.

Actuaries and Benefit Consultants
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Sen. Kennedy introduced the bill saying, "I believe this plan will help, not hurt, American business as it struggles to compete in world markets...the manufacturing firms that are at the cutting edge of international trade competition almost universally insure their workers - and they pay too much because other firms pay too little."

Sen. Kennedy's position is that all employees should have access to quality health care. But behind this rhetoric is an insidious transfer of costs from large and unionized companies to non-union, business service companies and mostly non-union manufacturing companies.

Cost shifting among plans and companies which results from the free operation of the marketplace is all right. If some of the plans which are "paying too much" were to be more realistic in their labor negotiations, then the marketplace would result in a more equitable distribution of participants among companies.

Instead, unions and businesses provide benefits which are too rich and often free to the whole family without requiring the employee to pay any premium. In so doing, they invite and should expect more participants and higher liabilities. Legislating to bail out these plans would save them money at the expense of other companies. It's no wonder this bill has the support of labor unions and "big business".

It has been reported that big business endorces the bill because they are paying too much for uncompensated care provided by hospitals to people without coverage. Uncompensated care is a problem, but for union and some other large companies it seems to be a smokescreen hiding the real issue which is this shift of costs to other companies. And if other companies do support the bill because of the uncompensated care issue, they should take another look at the costs they will incur if the inability of an employee to choose other coverage remains in the bill.

I support giving employees access to health insurance if they and their employers can afford it. Most employees already have access to health insurance. And if Congress makes employers adopt a minimum plan and makes them pay something toward it (although less than 80%), that might be acceptable. My main objection is that employees should be able to freely choose among the options available to them. Where a family has two working spouses, they should be free to choose whichever coverage best meets their needs. They should not be forced into one plan or the other.

Sincerely,

YAFFE & COMPANY, INC.

Ri M Yaffe

Rian M. Yaffe,
President

Senator **Mulkulski**. I will tell you what we are departing to and why we wanted to move more crisply. At 2 p.m., the entire Senate for the 100th Congress will convene for a picture. It is really for our Bicentennial photo. And I will tell you, since I was precluded from the first draft of the Constitution, I am going to be there for this picture.

So we thank you for your participation and look forward to working with you.

[Whereupon, at 1:56 p.m., the Committee was adjourned.]

○